

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>12 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING,</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>60 DOUGLAS AVE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HAMILTON</b>		First <b>M.</b>		Middle <b>ANDERSON</b>		Last <b>ANDERSON</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>12</b> Year <b>1966</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-3-1923</b>		9. AGE (In years last birthday) <b>42 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Aluminum Plant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>HAMILTON ANDERSON</b>					14. MOTHER'S MAIDEN NAME <b>ANNA M. MITCHELL</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>216-18-1571</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Terminal Congestive heart failure</b> <b>260X</b> DUE TO (b) <b>2. Metabolic acidosis severe</b> DUE TO (c) <b>3. arteriosclerotic cardiovascular renal disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4. Diabetes mellitus 24 years</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 week</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>28 May, 1963</b> , to <b>12 Jan, 1966</b> , that (I) (we) last saw the deceased alive on <b>11 Jan. 1966</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. W. A. Vanormer</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VANORMER</b>					22d. ADDRESS <b>122 S. CENTRE ST.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill</b>		23d. LOCATION (City, town or county) (State) <b>West Lonaconing Md.</b>			
24. FUNERAL DIRECTOR <b>Carl Bral Westernport, Md.</b>					25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>		

9500

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00002

00002

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u> <u>01-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. # 3 Bedford Rd.</u>		d. STREET ADDRESS <u>Rt. # 3 Bedford Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Glendon</u> Last <u>Armbruster</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1906</u>
9. AGE (In years last birthday) yrs. <u>60</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio-TV Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Radio Shop Prop.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Raymond W. Armbruster</u>		14. MOTHER'S MAIDEN NAME <u>Maude E. Wolford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No,</u>		16. SOCIAL SECURITY NO. <u>136-22-6197</u>	
17. INFORMANT <u>Mr. William J. Armbruster</u>		Address <u>Rt. # 3 Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/25</u> , 19 <u>65</u> , to <u>1/31</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>66</u> , and that death occurred at <u>1 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo H. Ley, Jr.</u>		ADDRESS (Street, city or town, state) <u>456 N. Centre St.</u> DATE SIGNED <u>2/2/66</u>	
PHYSICIAN'S NAME (Type) <u>Leo H. Ley, Jr. M.D.</u>		<u>Cumberland, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/2/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>B 4</u> DATE <u>1966</u>		24b. REGISTRAR'S SIGNATURE <u>Johnes Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00000

0000

RECEIVED  
FEB 10 1964  
U.S. AIR FORCE  
HEADQUARTERS  
AIR FORCE  
WASHINGTON, D.C.

50 1000 10



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00003

00003

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN b <b>4 Months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>213 Davison Street</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Hampshire</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Junction</b> d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Rosie</b> Last <b>Arnold</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Frances Mongold</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-42-7521</b>	
17. INFORMANT <b>Howard Arnold, Springfield, W. Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4221 DUE TO (b) <b>ASC V disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>		22. DATE SIGNED <b>Jan. 7, 1966</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIK MD</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 10, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Indian Mound</b>		23d. LOCATION (City, town or county) (State) <b>Romney W. Va.</b>	
24. FUNERAL DIRECTOR <b>John J. [Signature]</b>		25a. REC'D BY REGISTRAR <b>Jan 11 1966</b>	
ADDRESS <b>Romney, W. Va.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00000

MEMORANDUM FOR THE DIRECTOR

00000

1. Summary

2. Details

3. Recommendations

4. Action

5. Comments

6. Distribution

7. Status

8. Date

9. Page

10. Total

11. Remarks

12. Initials

13. Date

14. Status

15. Remarks

16. Initials

17. Date

18. Status

19. Remarks

20. Initials

21. Date

22. Status

23. Remarks

24. Initials

25. Date

26. Status

27. Remarks

28. Initials

29. Date

30. Status

31. Remarks

32. Initials

33. Date

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

00004

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00004

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>				e. STREET ADDRESS <b>MIDLAND</b>			
3. NAME OF DECEASED (Type or print) <b>JAMES BAMPTON</b>				4. DATE OF DEATH <b>JANUARY 5, 19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 15, 1877</b>	
9. AGE (in years last birthday) <b>88 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED STATION AGENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P R. R.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ENGLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH BAMPTON</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN HENLEY</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>702-07-5609</b>		17. INFORMANT <b>MISS ELLEN BAMPTON, MIDLAND, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>4321</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NONE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>25 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>AUGUST, 19 62</b> to <b>5 JAN., 19 66</b> , that (I) (we) last saw the deceased alive on <b>5 JAN. 19 66</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Martin Rothstein M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN ROTHSTEIN, M. D.</b>				22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-8-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>		23d. LOCATION (city, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>				25a. REC'D BY REGISTRAR <b>1 JAN 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00000

00000

00000

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00005 CERTIFICATE OF DEATH 00005									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>50 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>110 W. FIRST STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>EDNA</b> <b>M</b> <b>BECK</b>			4. DATE OF DEATH <b>JANUARY</b> <b>14</b> <b>1966</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <b>8-24-01</b>		9. AGE (in years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK - Hoasic</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>EDWARD F. TRACY</b>						
14. MOTHER'S MAIDEN NAME <b>HARRIETT MATTHEWS</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>						
16. SOCIAL SECURITY NO. <b>216-22-5212</b>			17. INFORMANT <b>PT'S CHART</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting aneurysm, ascending aorta</b> DUE TO (b) <b>Arteriosclerotic and hypertensive CVD</b> DUE TO (c) <b>5 years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fibrosis following the</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>9 - 22</b> , 19 <b>63</b> , to <b>1 - 14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1 - 14</b> , 19 <b>66</b> , and that death occurred at <b>6p</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. R. Ballin</b>			22b. DATE SIGNED <b>1-15-66</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. R. BALLIN, MD.</b>				
22d. ADDRESS <b>62 GREENE ST. CUMBERLAND, MD. 21502</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						
23b. DATE THEREOF <b>Jan. 17, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>					
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>			25a. REC'D BY REGISTRAR <b>JAN 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

00005

00000

170 W. 17th Street  
New York, N.Y.

170 W. 17th Street

New York, N.Y.

170 W. 17th Street

New York, N.Y.

Interleukin-6 and hypercortisolemia  
in patients with rheumatoid arthritis

x

Interleukin-6 and hypercortisolemia

00

1 - 11

03

2 - 21

00

00

1 - 11

1-15-00

x

1-15-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00006 CERTIFICATE OF DEATH 00006									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>20 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LA VALE</b> d. STREET ADDRESS <b>102 WEIGAND DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>Arlen</b> Last <b>BITTNER</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>22</b> Year <b>1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 2, 1910</b>		9. AGE (in years last birthday) <b>55</b> yrs. IF UNDER 1 YEAR: Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Service station</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA, Berlin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BITTNER</b>					14. MOTHER'S MAIDEN NAME <b>SADIE KEEFER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-10-8651</b>		17. INFORMANT <b>Mrs. Mary L. Bittner, LaVale, Md.</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ventricular tachycardia</b> DUE TO (c) <b>Acute myocardial infarction</b>								INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>4 days</b> <b>20 days</b>	
								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
								PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-3</b> , 19 <b>66</b> , to <b>1-22</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-22</b> , 19 <b>66</b> , and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>William P. James</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/23/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM P. JAMES</b>					22d. ADDRESS <b>441 N. CENTRE ST., CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Gardens</b>			23d. LOCATION (City, town or county) (State) <b>LaVale, Md.</b>		
24. FUNERAL DIRECTOR <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

00000

0000

ALLIED

AND

OFFER

LAVAL

CHURCH

101 WEST 10TH ST

MEMORIAL HOSPITAL

22 MAY

1917

GEORGE

1017 N. 10TH ST

WHITE

PENNSYLVANIA

PHILADELPHIA

SADIE KESTER

JOHN B. JONES

1-10-1917

1017 N. 10TH ST

PHILADELPHIA

WHITE

1017 N. 10TH ST

PHILADELPHIA

1017 N. 10TH ST

PHILADELPHIA

PHILADELPHIA

PHILADELPHIA

PHILADELPHIA

# 1

## FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00007

### MARYLAND STATE DEPARTMENT OF HEALTH

#### Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00007

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Bedford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Flintstone</u>				c. LENGTH OF STAY IN 1b <u>75-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 40</u>				d. STREET ADDRESS <u>Route 2, Flintstone, Md</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>May</u> Last <u>Bridges</u>				4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>KI</u> <u>OR</u> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10, 1896</u>	9. AGE (in years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>George Robinette</u>				
14. MOTHER'S MAIDEN NAME <u>Delilah Roland</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>  </u>			17. INFORMANT <u>Margaret Poling</u> Address <u>948 Frederick St</u> <u>Cumberland</u> <u>Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>1/ 7/66</u>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>		Address (Street, city, town, or county) <u>  </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan 9, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beans Cove Methodist Cem.</u>	23d. LOCATION (City, town or county)	(State) <u>Penna</u>			
24. FUNERAL DIRECTOR <u>John J. Zuber</u>		ADDRESS <u>230 Balto Ave., Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 11 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

00007

0000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF

Blank form with faint horizontal lines for text entry.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
5M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admision) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Allegany</u></span>												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN lb <u>60 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			d. STREET ADDRESS <u>100 Laing Ave.</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>100 Laing Ave.</u>					d. STREET ADDRESS <u>100 Laing Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Harry Cleveland Burns</u>					<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>30</u> Year <u>1966</u>												
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug. 10, 1884</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Inspector</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Railroad</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Cumberland, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>Jacob Burns</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Gaver</u>												
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mrs. Virginia Forbeck, Cumberland, Md.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one causa per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 4201 DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying causa last. (b) <u>---</u> DUE TO (c) <u>---</u>									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>SUDDEN</u>								
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a)</b>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)										
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitarelic</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>22. DATE SIGNED</b>									
<b>EXAMINER'S NAME (Type)</b> <u>Dr. Benedict Skitarelic, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<u>Cumberland, Md.</u>									
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>Address (Street, city, town, or county)</b>				<u>Jan. 30, 1966</u>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>Feb. 2, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenmount Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Cumberland, Md.</u>										
<b>24. FUNERAL DIRECTOR</b> <u>James F. Scarpelli, Cumberland, Md.</u>						<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>									
<b>DATE</b> <u>4</u> <u>1966</u>																	

372

BOOK

BOOK

THE  
JANUARY





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>111 S. Lee St.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>111 S. Lee St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Walter B Clegggett</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>28</u> Year <u>1966</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 17, 1902</u>		9. AGE <u>63</u> yrs. (last birthday)		IF UNDER 1 YEAR Months <u>01</u> Days <u>-1</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Fireman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O R.R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William Clegggett</u>					14. MOTHER'S MAIDEN NAME <u>Mary E. Bailey</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Jennie Thompson</u> Address <u>Pittsburgh, Pa.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung c</u> <u>163X</u> DUE TO (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis + Hypertensive Heart Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/31/1965</u> , 19 <u>60</u> , to <u>1/28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/31/1965</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Steelesman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/27/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>S G WEISMAN MD</u>				22d. ADDRESS <u>59 Green St Cumberland, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 31, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>				23d. LOCATION (City, town or county) <u>Cumberland</u> (State) <u>md.</u>			
24. FUNERAL DIRECTOR <u>Louis Stem, Inc.</u>				ADDRESS <u>Cumberland, Md</u>		25a. REC'D BY REGISTRAR <u>FEB 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

00000

00000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>															
<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>13 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>245 N. MECHANIC ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) <b>MILDRED</b> First Middle Last			<b>4. DATE OF DEATH</b> <b>JANUARY 27 19 66</b> Month Day Year		<b>5. SEX</b> <b>FEMALE</b>			<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-9-02</b>		<b>9. AGE</b> (In years last birthday) <b>63</b> yrs.           IF UNDER 1 YEAR: Months <b>27</b> Days <b>19</b> Hours <b>66</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>WALTER VINEY</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>CAROLINE VINEY</b>										
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>			<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>PATIENT'S CHART</b>			Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease with chronic congestive failure</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>  <b>2 months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute thrombosis, right femoral artery (corrected); Diabetes</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)								
<b>21. I certify that (I) (this hospital) attended the deceased from December 27, 1965, to Jan. 27, 1966, that (I) (we) last saw the deceased alive on January 27, 1966, and that death occurred at 7:20M, from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <i>Wand F. Doerner, Jr.</i>					<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>AM. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>Jan. 29, 1966</b>								
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>WYAND F. DOERNER, JR. M.D.</b>					<b>22d. ADDRESS</b> <b>414 N. MECHANIC ST., CUMBERLAND, MD.</b>										
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>JAN 31 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ST. MICHAELS CATHOLIC CEM.</b>			<b>23d. LOCATION</b> (City, town or county) (State) <b>FROSTBURG MARYLAND</b>							
<b>24. FUNERAL DIRECTOR</b> <b>John J. Hafer</b>					<b>25a. REC'D BY REGISTRAR</b> <b>FEB 1 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>								

0001

0001

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00011 CERTIFICATE OF DEATH 00011											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSP.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>420 PINE PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>OCTAVIA</b> First <b>KIM</b> Middle <b>PRISCILLA</b> Last <b>CROTHERS</b>						4. DATE OF DEATH <b>JANUARY 24</b> Month <b>24</b> Day <b>19</b> Year <b>66</b>					
5. SEX <b>FEM.</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-4-1899</b>		9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>PAW PAW, WEST VIRGINIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Engle</b> <b>DEC.</b>						14. MOTHER'S MAIDEN NAME <b>Rachael Fishel</b> <b>DEC.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>BRUCE CROTHERS</b> Address <b>HUSBAND 420 PINE PL.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 <b>63</b> , to <b>1-24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-22</b> , 19 <b>66</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>L. Michael Gentry</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-25-66</b>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Near Cumberland, Md.</b>			
24. FUNERAL DIRECTOR <b>John F. Hafer</b>						ADDRESS <b>230 Balto Ave., Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>1</b> 25b. REGISTRAR'S SIGNATURE <b>John F. Hafer</b>			
DATE <b>1</b> 1966											

00011

00011

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

LIFE

CUMBERLAND

420 PINE PLACE

SACRED HEART HOSP.

CC

24

JANUARY

BROTHERS

ANN

OCTAVIA

CC

9-4-1893

X

WHITE

FEM.

HOUSEWIFE

DEC.

DEC.

WILLIAM

BRUCE BROTHERS HUSBAND 420 PINE PL.



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2000 BY SP-6 JLD/STP



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00012

00012

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG, 01-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL CO.</b>				d. STREET ADDRESS <b>54 W. MECHANIC STREET,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle Last <b>CULLEN</b>				4. DATE OF DEATH Month <b>1</b> Day <b>28</b> Year <b>1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/31/09</b>		9. AGE (In years last birthday) <b>56 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE CORP.</b>		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DANIEL J. CULLEN</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA M. McKEE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-01-3687</b>		17. INFORMANT <b>MISS MARY C. GRIMES, 54 W. MECHANIC ST., FROSTBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>				22. DATE SIGNED <b>January 28, 1966</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-31-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.,</b>				ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>FEB 3 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10015

10015

10015

10015

10015

10015

10015

10015

10015

10015

10015

10015

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00013

00013

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>40 YEARS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>XXX 508 PEARRE AVE.</u>				d. STREET ADDRESS <u>508 PEARRE AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>F.</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>30</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 1, 1893</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		11. BIRTHPLACE (State or foreign country) <u>KAYSER, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES E. DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>LENA MERRYMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705 09 9838</u>		17. INFORMANT <u>MARGUERITE TIDWELL</u>		Address <u>CUMBERLAND, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>CORONARY OC CLUSTON</u> DUE TO (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC C, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>January 30, 1966</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST BURIAL PARK</u>		23d. LOCATION (City, town or county) (State) <u>CUMBERLAND, MD.</u>	
24. FUNERAL DIRECTOR <u>BYRON KIGHT</u>		ADDRESS <u>CUMBERLAND, MD.</u>		25a. REC'D BY REGISTRAR <u>FEB 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

1000

Benjamin Franklin

1750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1. and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>CERTIFICATE OF DEATH</b>											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				d. STREET ADDRESS <b>3 BOONE STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>FLEDA V. DAVIS</b>			First Middle Last			4. DATE OF DEATH <b>JANUARY 15 19 66</b>			Month Day Year		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-25-1903</b>		9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOHN GORDON</b>						14. MOTHER'S MAIDEN NAME <b>DELIA BELTS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Fibrosis &amp; Emphysema</b> 525X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Hypoxia</b> DUE TO (c) <b>Myocardial Sclerosis</b> DUE TO										INTERVAL BETWEEN ONSET AND DEATH <b>1-2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)		20g. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/2/64</b> , 19 to <b>1/15/66</b> , 19, that (I) (we) last saw the deceased alive on <b>1/14/66</b> , 19, and that death occurred at <b>2:40 A.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>[Signature]</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/15/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>						22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 17, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>18 JAN 18 1966</b>			
24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

00014

00014

ALL EGGAN

MORTLAND

ALL EGGAN

CUMBERLAND

2 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

3 300th STREET

FIELD

DAVIS

JANUARY 15

9-15-1903

WHITE

HOUSEWIFE

CUMBERLAND, MD.

U.S.A.

JOHN GORDON

CELLA BELLE

MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. R. J. WILLIAMS

123 S. CENTRAL

CUMBERLAND, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00015					00015						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		Allegany			a. STATE		b. COUNTY				
		MARYLAND			Maryland		Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Rural Westernport			30 Years		Rural Westernport 01-1						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?			
rural Stoney Run Road					rural Stoney Run Road			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle	Last	4. DATE OF DEATH		Month	Day	Year	
Lottie					Davis	January		21	19	66	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 10, 1876		89 yrs.		Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Housewife			Domestic		West Virginia			U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Michael Davis					Jane Thompson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
no			none		Mrs. Owen Rhodes			Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										15 Days	
IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage											
DUE TO (b) Hypertension										10 Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from Jan 6, 1966, to Jan 21, 1966, that (I) (we) last saw the deceased alive on Jan 7 1966, and that death occurred at 6:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE					22b. DATE SIGNED						
Paul R. Wilson					Jan 24, 1966						
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
Paul R. Wilson					Piedmont, W. Va.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county)			(State)	
Burial		1/24/66		Llewellyn Cemetery			Barton, Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
E. J. Bural					DATE JAN 25 1966			J. Charles Judge			
Westernport, Md.											

00015

00015

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Date of birth

4. Place of birth

5. Date of death

6. Place of death

7. Cause of death

8. Signature of physician

9. Signature of registrar

10. Signature of witness

11. Date of registration

12. Place of registration

13. Date of burial

14. Place of burial

15. Date of cremation

16. Place of cremation

17. Date of interment

18. Place of interment

19. Date of exhumation

20. Place of exhumation

21. Date of reinterment

22. Place of reinterment

23. Date of removal

24. Place of removal

25. Date of return

26. Place of return

27. Date of disposal

28. Place of disposal

29. Date of burial

30. Place of burial

31. Date of cremation

32. Place of cremation

33. Date of interment

34. Place of interment

35. Date of exhumation

36. Place of exhumation

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>            Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>D O A</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Allegany</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale</u> <u>01-1</u> d. STREET ADDRESS <u>45 National Highway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Walter</u> Middle <u>Eugene</u> Last <u>Derlan</u> <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 14, 1924</u> <b>9. AGE</b> (In years last birthday) <u>41</u> yrs. <b>10. OAT OF BIRTH</b> <u>March 14, 1924</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>					<b>13. FATHER'S NAME</b> <u>Herman B. Derlan</u> <b>14. MOTHER'S MATEEN NAME</b> <u>Rose Riggleman</u> <b>15. WAS OCEASED EVER IN U.S. ARMOEFORCE?</b> (Yes, no, or unknown) <u>Yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>WW 2 218-16-2779</u> <b>17. INFORMANT</b> <u>Mrs. Mildred G. Derlan-45 Nat'l Hwy, La Vale</u> <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis With Thrombosis</u> IMMEDIATE CAUSE (c) <u>---</u> PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>---</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> - NO <input type="checkbox"/>				
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. OESCRIBE HOW INJURY OCCURREO.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u> <b>20d. INJURY OCCURREO</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>					<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined manner</b> <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>January 24, 1966</u> <b>22. DATE SIGNED</b> <b>EXAMINER'S NAME (Type)</b> <u>BENEDICT SKITARELIC, M.D.</u> <b>Address (Street, city, town, or county)</b> <u>Cumberland, Md.</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Jan. 27, 1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Burial Park</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Cumberland, Maryland</u>					<b>24. FUNERAL DIRECTOR</b> <u>John J. Hofer</u> <b>ADDRESS</b> <u>230 Balto Ave., Cumberland, Md</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE</b> <u>FEB 1 1966</u>				

00010

00010

1946  
1947

7

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50

BP

00017

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00017

1. PLACE OF DEATH a. COUNTY <b>ALLE GANY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPI TAL</b>			d. STREET ADDRESS <b>328 FAYETTE ST.</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARL EMERY DICKEN</b>			4. DATE OF DEATH Month Day Year <b>JANUARY 17 19 66</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-21-1903</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>JOHN E. DICKEN</b>			14. MOTHER'S MAIDEN NAME <b>LEDA MAY FISHER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>214-05-5071</b>		
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). 1 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>22 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State) <b>Cumberland, Allegany</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>1/12/66</b> , 19 <b>19</b> , to <b>1/17/66</b> , 19 <b>19</b> , that (I) (we) last saw the deceased alive on <b>1/16/66</b> , 19 <b>19</b> , and that death occurred at <b>12 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>			22b. DATE SIGNED <b>1/19/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>			22d. ADDRESS <b>122 S. CENTRE ST. Cumb. Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/20/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>	
23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>		24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>			
25a. REC'D BY REGISTRAR <b>JAN 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

books

books

ALL DAY

CUNEB LAND

MEMORIAL HOSPITAL

CASE

WHITE

JOHN E. DICKEN

24-07-1901

RAYMOND

EDNA MAY KILMER

CHAMBERLAND, J.

DR. R. J. WILLIAMS

122 S. CENTRE ST.

1120133

H. STANLEY LINDORF, BIRMINGHAM, ALABAMA



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00018

00018

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA VALE</b>		c. LENGTH OF STAY IN 1b <b>15 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA VALE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>220 NATIONAL HIGHWAY</b>				d. STREET ADDRESS <b>220 NATIONAL HIGHWAY</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT W. DIGGS</b>				4. DATE OF DEATH Month Day Year <b>JAN. 21 19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 22 1910</b>		9. AGE (In years last birthday) <b>55 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JEWELER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN W. DIGGS</b>				14. MOTHER'S MAIDEN NAME <b>IRENE ROBERTS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214 05 5730</b>		17. INFORMANT <b>MRS. ELENORE DIGGS</b>		Address <b>LA VALE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		January 21, 1966		Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>				ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 24 1966</b>	
				25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>			

00018

00018

IS

SS

THE ISLAND

THE ISLAND

THE ISLAND

THE ISLAND

THE ISLAND

THE ISLAND

THE ISLAND

THE ISLAND

THE ISLAND

THE ISLAND

THE ISLAND

1  
FOR STATE  
HEALTH DEPT.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00019

00019

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nikep</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nikep</b> d. STREET ADDRESS <b>01-1</b>		
3. NAME OF DECEASED (Type or print) First <b>ANGUS</b> Middle <b>DONALDSON</b> Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4. DATE OF DEATH Month <b>1/28/1966</b> Day <b>19</b> Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18th. 1892</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Paper Mill, Luke, MD.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>William Donaldson</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes World War # 1</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert Donaldson Nikep, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Aorta</b> 8124 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>(Struck by Automobile)</b> (c) DUE TO (e), stating the underlying causa last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by automobile</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>8:30</b> p.m. <b>1/28/1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway Nikep Allegany MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D.		DATE SIGNED <b>Jan, 28th. 1966</b>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>		<b>Cumberland, MD.</b>		22d. LOCATION (City, town, or country) (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/31/1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEMETERY MOSCOW, MD.</b>	
23. FUNERAL DIRECTOR <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, MD.</b>		24a. REC'D BY REGISTRAR <b>FEB 1 1966</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05000

Y. S. Kim, J. Kim, and J. Kim

• 04 • 11/05/2010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
Items #8 & 9 Film #G373 2/11/66 ps													
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>						c. LENGTH OF STAY IN 1b <b>33 DAYS</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>CLARA</b>			First Middle Last <b>D. ELLIOTT</b>			4. DATE OF DEATH Month Day Year <b>JANUARY 28, 1966</b>							
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1882</b> <b>8-30-1888</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>XENIA, ILLINOIS</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>EDWARD GRIFFIN</b>						14. MOTHER'S MAIDEN NAME <b>MARIN JANE RANKIN</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMB. MD.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>For advanced hypotensive Cardiac</b> <b>443X</b> DUE TO (b) <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Cholelithiasis - many years duration</b>												INTERVAL BETWEEN ONSET AND DEATH <b>12-26-65</b> <b>Between 11:00-12:00</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>12-26-1965</b> to <b>1-28-1966</b> , that (I) <del>was</del> last saw the deceased alive on <b>1-28-1966</b> , and that death occurred at <b>8:45 PM</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Wm. F. Williams</b>						22b. DATE SIGNED			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>						22d. ADDRESS <b>122 S. CENTRE ST.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>JAN. 31, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>			23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>					
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>						25a. REC'D BY REGISTRAR <b>FEB 2 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

100-20

100-20

ALICE TARY

MARYLAND

ALLEGANY

CUMBERLAND

33 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

O. W. WAVERLY TERRACE

CLARA

ELLIOTT

JANUARY 28, 1906

FEMALE WHITE

6-30-1888

17

EDWARD GRIFFIN

MARTIN JANE BART

KEWNA, ILLINOI

MEMORIAL HOSPITAL, CUM., MD.

DR. W. F. WILLIAMS

152 S. CENTRE ST.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place in the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00021  
CERTIFICATE OF DEATH

00021

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>Appx. 70 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>604 Montgomery Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>604 Montgomery Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Margaret Elizabeth Enlow</u>		<b>4. DATE OF DEATH</b> <u>Jan. 10 1966</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan. 10, 1881</u>		<b>9. AGE</b> (In years last birthday) <u>85</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Selbyport, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>											
<b>13. FATHER'S NAME</b> <u>Lloyd Lowdermilk</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Lowdermilk</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>				<b>17. INFORMANT</b> <u>Mrs. Erma Moore</u> Address <u>Cumberland, Md.</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> 4221 DUE TO <u>myocarditis &amp; Exsanguination</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>																<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 wks</u> <u>1 yr</u> <u>5 yr</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>  </u> 19 <u>  </u> Hour a.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 1964</u> <b>to</b> <u>Jan 10, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 6, 1966</u> <b>and that death occurred at</b> <u>  </u> <b>M, from the causes and on the date stated above.</b>																							
<b>22a. SIGNATURE</b> <u>Clayton L. Lurcott</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>1/11/66</u>															
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b>																			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Jan. 13, 1966</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenmount Cem.</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Cumberland Md.</u>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lewis Stein, Inc.</u>				<b>ADDRESS</b> <u>Cumberland, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>JAN 14 1966</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>											

00000

00000

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

Billings

1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00022

00022

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>WESTERNPORT</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>27 MAIN STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>DEWEY</b> Middle <b>L</b> Last <b>FAZENBAKER</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>31</b> Year <b>1966</b>	
5. SEX <b>MAL E</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>XXXX 319-98</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Fazenbaker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Kerns</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-03-7872</b>	
17. INFORMANT <b>PT'S CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cronic Glomerulonephritis</b> DUE TO (c) 592X			INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>January 31, 1966</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/3/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>	23d. LOCATION (City, town or county) (State) <b>Westernport, Md.</b>
24. FUNERAL DIRECTOR <b>El. Boul</b>		25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

88000

88000

M

37-45

1900  
1901

Grant Jones, Jr.

X

X

X

X

1902, 1903  
1904, 1905

RECEIVED BY THE U.S. DEPT. OF AGRICULTURE

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00023					00023						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>						
c. LENGTH OF STAY IN 1b <b>1 DAY</b>					d. STREET ADDRESS						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year			
<b>ERNEST S. FAZENBAKER</b>						<b>JANUARY 6 1966</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-14-1888</b>		9. AGE (in years last birthday) <b>77</b> yrs.			
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>GARRETT COUNTY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>OLIVER FAZENBAKER</b>					14. MOTHER'S MAIOMEN NAME <b>FLORENCE WARNICK</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b> <b>4201</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis + Rheumatic HT Disease</b> (c) <b>Previous cerebral embolus - 1 day prior - healed</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous cerebral embolus - 1 day prior - healed</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Instantly</b> <b>Include</b> <b>Include</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 5, 1966</b> to <b>Jan 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 6, 1966</b> , and that death occurred at <b>3:59 PM</b> on the causes and on the date stated above.											
22a. SIGNATURE <b>S. G. Weisman</b>					22b. DATE SIGNED <b>1/9/66</b>			22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>			
22d. ADDRESS <b>59 GREENE ST.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City, town or county) (State) <b>Westernport Md.</b>				
24. FUNERAL DIRECTOR <b>S. G. Weisman</b>					25a. REC'D BY REGISTRAR <b>JAN 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

00003

ILLEGALLY

WENTLAND

WESTMONT

1.0.0

WENTLAND

CUMBERLAND

MEMORIAL HOSPITAL

PATENT

ERNST

11-14-1965

WILEY

CARLETT

OLIVER PATENT

MEMORIAL HOSPITAL

OF GRANT

DR. J. C. WILSON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00024 CERTIFICATE OF DEATH						00024					
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>Cumberland</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b> d. STREET ADDRESS <b>Beechwood Street</b> 01-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>PRISCILLA</b>			First Middle Last <b>Frye</b>			4. DATE OF DEATH <b>1/6/1966</b>			Month Day Year <b>19</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 24th. 1892</b>		9. AGE (in years last birthday) <b>73</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Midland, MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Louis Knippenberg</b>						14. MOTHER'S MAIDEN NAME <b>Susanne Retalick</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Harvey Frye</b>		Address <b>Lonaconing, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 years</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture, left femur. Diabetes mellitus</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3 - 27</b> , 19 <b>64</b> , to <b>1 - 6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1 - 6</b> , 19 <b>66</b> , and that death occurred at <b>8a</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Ralph W. Ballin, Md.</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-7-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, Md.</b>						22d. ADDRESS <b>62 Greene St. Cumberland, Md 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/8/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg, MD.</b>					
24. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b>						ADDRESS <b>Lonaconing, MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00024

00024

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

X

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

Library

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

00025

00025

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hosptal</b>		d. STREET ADDRESS <b>Cumberland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma Olivia Geary</b>		4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 3, 1872</b>	9. AGE (In years last birthday) <b>93</b> yrs.	IF UNDER 1 YEAR Months <b>30</b> Days <b>19</b> Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Keyser W. Va.</b>	
13. FATHER'S NAME <b>Andrew Robey</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. Peters</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Katie G. Uhl, Cumberland Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC MYOCARDITIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>contusion of right shoulder with thrombosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>Fell at home</b>			
20c. TIME OF INJURY Month, Day, Year <b>10:00 a.m. Jan. 5 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Cumberland, Alleg. Maryland</b>	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitaralic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>Jan. 30, 1966</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARALIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 5, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Savage Meth. Cent.</b>		23d. LOCATION (City or Town) (County) (State) <b>Mt. Savage Maryland</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumberland Maryland</b>		25a. REC'D BY REGISTRAR <b>Feb 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

28000

28000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00026 CERTIFICATE OF DEATH 00026											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY COUNTY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>17 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>220 UNION ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>VIOLA</b> Last <b>GEORGE</b>						4. DATE OF DEATH Month <b>JAN</b> Day <b>23</b> Year <b>19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-25-1897</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>23</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rockoak West Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DAVID RIGGLEMAN</b>						14. MOTHER'S MAIDEN NAME <b>PHOEBE EVERSOLE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Luther R. George</b>			Address <b>220 Union Street Cumberland, Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1 Renal failure</b> <b>4201</b> DUE TO (b) <b>2 Infarction right kidney</b> <b>3 Embolization renal artery</b> <b>4 NEPHROSCLEROSIS</b> <b>5 OLD PYELONEPHRITIS</b> DUE TO (c) <b>6 Cerebrovascular Hypertensive Cardiovascular disease</b> <b>7 Atrial Thrombus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b> <b>Coronary heart failure</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8</b> , 19 <b>65</b> , to <b>1/23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/23</b> 1966, and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>S. G. Weisman</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/23/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>						22d. ADDRESS <b>59 GREENE ST. CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Gardens</b>			23d. LOCATION (City, town or county) (State) <b>LaVale Maryland</b>		
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>						ADDRESS <b>Cumberland Maryland 21502</b>		25a. REC'D BY REGISTRAR <b>Jan 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Jones</b>	

00038

ALLEGANY

ALLEGANY COUNTY

ALLEGANY COUNTY

CHERRYLAND

CHERRYLAND

MEMORIAL HOSPITAL

220 UNION ST.

MYRLE

00038

JAN

08

1-1-1924

WHITE

FEMALE

DAVID RIGGEMAN

CHERRYLAND

1:30 PM

DR. S. D. WEISMAN 22 GREENE ST. CHERRYLAND, MD.

DR. S. D. WEISMAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00027											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN ID <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b> d. STREET ADDRESS <b>209 FIFTH ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>ATHOL N. GIBSON</b>						4. DATE OF DEATH Month Day Year <b>JAN. 24 1966</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 21, 1895</b>		9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AMBROSE H. BIBSON</b>						14. MOTHER'S MAIDEN NAME <b>LILLIE GENTRY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> War <b>I</b>				16. SOCIAL SECURITY NO. <b>705-07-2881</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary + Myocardial Insufficiency</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1/22/66 4:10 P.M. 1/24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/24</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. L. H. Ley</b>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/28/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. LEO H. LEY</b>						22d. ADDRESS <b>456 N. CENTRE ST. CUMB. MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 27, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			

00037

00037

ALLEGANY MARYLAND

CUMBERLAND MENTAL HOSPITAL  
200 FIFTH ST.  
DAY

ATHOL N. GIBSON  
MALE WHITE  
OCT. 21, 1892 70

ALBROSE H. GIBSON  
CUMBERLAND  
U.S.A.  
LILLIE GIBSON  
MENDHAM N.J.

4:10 P.M.

DR. LEO H. ZEY  
550 N. CENTRE ST. ELMHURST, ILL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
DR. W. F. WILLIAMS 00028 CERTIFICATE OF DEATH 00028											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>5 HRS. 20 MIN.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>16 FIFTH STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOHN P. GORDON</b>			First Middle Last			4. DATE OF DEATH <b>JANUARY 28 19 66</b>			Month Day Year		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-31-1890</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MADISON, VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WALTER W. GORDON</b>						14. MOTHER'S MAIDEN NAME <b>SALLY S. PAYNE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes War I</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Cholecystitis, Chronic Prostatitis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-27-1966</b> to <b>1-28-1966</b> , that (I) (we) last saw the deceased alive on <b>1-27-1966</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>W. F. Williams</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-28-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>						22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 30, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>				23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>558 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

0002X

ALLEGANY

MARYLAND

CUMBERLAND

HWS. 20 MIN.

16 FIFTH STREET

JANUARY 23 1950

GORDON

R.

JOHN

75

10-31-1950

U.S.A.

MADISON, VIRGINIA

SALLY S. PAYNE

MEMORIAL HOSPITAL-CUMBERLAND, MD.

DR. F. WILLIAMS

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

WHITE

MALE

RETIRED

WALTER W. GORDON

DR. F. WILLIAMS

123 S. CENTRAL ST., CUMBERLAND, MD.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>1</div> <div>00029</div> <div>00029</div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div>											
<div>Allegany</div> <div>MARYLAND</div>						<div>2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Allegany</div>					
<div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Cumberland</div>						<div>c. LENGTH OF STAY IN 1b</div> <div>38 years</div>					
<div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Sylvan Retreat</div>						<div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Luke</div> <div>01-1</div>					
<div>d. STREET ADDRESS</div>						<div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>					
<div>3. NAME OF DECEASED</div> <div>(Type or print)</div> <div>First</div> <div>Bernard</div> <div>Middle</div> <div>Francis</div> <div>Last</div> <div>Gormley</div>						<div>4. DATE OF DEATH</div> <div>Month</div> <div>Jan.</div> <div>Day</div> <div>25</div> <div>Year</div> <div>1966</div>					
<div>5. SEX</div> <div>Male</div>		<div>6. COLOR OR RACE</div> <div>White</div>		<div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div>Aug. 31, 1896</div>		<div>9. AGE (In years last birthday)</div> <div>69 yrs.</div>		<div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>none</div>		<div>10b. KIND OF BUSINESS OR INDUSTRY</div>		<div>11. BIRTHPLACE (County &amp; State, or foreign country)</div> <div>Allegany, Maryland</div>				<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>			
<div>13. FATHER'S NAME</div> <div>Thomas Gormley</div>						<div>14. MOTHER'S MAIDEN NAME</div> <div>Mary Mullan</div>					
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>no</div>				<div>16. SOCIAL SECURITY NO.</div> <div>NONE</div>		<div>17. INFORMANT</div> <div>Address</div> <div>SYLVAN RETREAT RECORDS, CUMBERLAND, MD.</div>					
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>422.1</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b)</div> <div>(c)</div>										<div>INTERVAL BETWEEN ONSET AND DEATH</div>	
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</div>										<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>	
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div>				<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div>							
<div>20c. TIME OF INJURY</div> <div>Hour</div> <div>a.m.</div> <div>p.m.</div> <div>19</div>				<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>		<div>20f. (City or town)</div>		<div>(County)</div> <div>(State)</div>	
<div>21. I certify that (I) (this hospital) attended the deceased from.....July 1....., 1961, to.....Jan. 25....., 1966, that (I) (we) last saw the deceased alive on.....Jan. 25....., 1966, and that death occurred at 5 P.M., from the causes and on the date stated above.</div>											
<div>22a. SIGNATURE</div> <div>L. B. Mathews, M.D.</div> <div>M.D.</div>						<div>ATTENDING PHYS.</div> <div><input type="checkbox"/></div>		<div>MED. DIRECTOR</div> <div><input type="checkbox"/></div>		<div>STAFF PHYS.</div> <div><input type="checkbox"/></div>	
<div>22c. PHYSICIAN'S NAME (Type)</div>						<div>22d. ADDRESS</div> <div>49 Greene St., Cumberland, Md.</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div>		<div>23b. DATE THEREOF</div> <div>JAN. 28, 1966</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>ALLEGANY COUNTY CEMETERY</div>				<div>23d. LOCATION (City, town or county)</div> <div>CUMBERLAND, MD.</div>			
<div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>BYRON KIGHT</div>						<div>ADDRESS</div> <div>CUMBERLAND, MD.</div>		<div>25a. REC'D BY REGISTRAR</div> <div>FEB 1 1966</div>		<div>25b. REGISTRAR'S SIGNATURE</div>	

00000

CERTIFICATE OF DEATH

00000

*[Faint, mostly illegible text and lines, likely a form or certificate, with some handwritten markings.]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00030

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN ID 49 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 422 Warwick Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Francis Goss		4. DATE OF DEATH Month Day Year Jan. 5 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1916
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME S. Fred Goss		14. MOTHER'S MAIDEN NAME Anna R. Mc Donald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes War II		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary Hall Goss, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, GENERALIZED 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF STOMACH DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 Months Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M. D.		22. DATE SIGNED 1-5-1966 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Rt. 9, Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 8, 1966	
23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 11 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

00030

00030

Dr. Benjamin Franklin

Dr. Benjamin Franklin

Dr. Benjamin Franklin

Dr. Benjamin Franklin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

00031

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00031

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Douglas Avenue</b>		d. STREET ADDRESS <b>Douglas Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 1909</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Westernport, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Amann</b>		14. MOTHER'S MAIDEN NAME <b>Annie Keady</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>	
17. INFORMANT <b>John Green</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 4201 DUE TO (b) <b>ACVD &amp; hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , to <b>Jan 16, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 10 1966</b> , and that death occurred at <b>11 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L.R. Miles MD</b>		22b. DATE SIGNED <b>1-17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR MD</b>		22d. ADDRESS <b>Lonaconing Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/19/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Westernport, Md.</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		25. REC'D BY REGISTRAR <b>1966</b>	
25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

00001

00001

Alle my

Interstate

Ontario Avenue

My

Female White

House work

John Amann

Green

May 12, 1900

On Home

Wassenaar, Michigan

Annie Keady

John Green

Wassenaar

Wassenaar, Mich.

John Green

Wassenaar, Mich.

John Amann

John Amann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1- and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>00032</p> <p><b>MARYLAND STATE DEPARTMENT OF HEALTH</b> DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>DR. BRINSFIELD</b></p> </div> <div> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>00032</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>ALLEGANY</b> MARYLAND</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b></p>				
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b></p>					<p>c. LENGTH OF STAY IN 1b <b>24 DAYS</b></p>				
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b></p>					<p>d. STREET ADDRESS <b>406 PRINCE GEORGE STREET</b></p>				
<p>3. NAME OF DECEASED (Type or print) First Middle Last <b>LILLIE M. GRIFFIN</b></p>					<p>4. DATE OF DEATH Month Day Year <b>JANUARY 25 1966</b></p>				
<p>5. SEX <b>MALE</b></p>		<p>6. COLOR OR RACE <b>WHITE</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>12-5-1884</b></p>		<p>9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>NEW YORK Port Jervis</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>HENRY TEAL</b></p>					<p>14. MOTHER'S MAIDEN NAME <b>CATHERINE WAGNER</b></p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Uremia</b> DUE TO (b) <b>ASCV Disease and Scurvy</b> DUE TO (c) <b>Reunt intestinal obstruction due to strangulated hernia</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p>									<p>INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Reunt intestinal obstruction due to strangulated hernia</b></p>									
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <b>2 Jan, 1966</b> to <b>25 Jan, 1966</b>, that (I) (we) last saw the deceased alive on <b>JAN 25 1966</b>, and that death occurred at <b>11:40 P.M.</b> from the causes and on the date stated above.</p>									
<p>22a. SIGNATURE <b>Carlton Brinsfield</b></p>								<p>22b. DATE SIGNED</p>	
<p>22c. PHYSICIAN'S NAME (Type) <b>DR. CARLTON BRINSFIELD</b></p>								<p>22d. ADDRESS <b>401 DECATUR ST., CUMBERLAND, MD.</b></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>			<p>23b. DATE THEREOF <b>Jan. 28, 1966</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b></p>		<p>23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b></p>		
<p>24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b></p>						<p>25a. REC'D BY REGISTRAR <b>EB 1 1966</b></p>		<p>25b. REGISTRAR'S SIGNATURE <b>[Signature]</b></p>	

DR. BRINSFIELD

ALLEANY

CUMBERLAND

24 DAYS

CUMBERLAND

MARYLAND

MEMORIAL HOSPITAL

101 PRINCE GEORGE STREET

LILLIE

M.

GRIFITH

12-2-1889

MALE WHITE

HOUSEWIFE

NEW YORK

HENRY TEAL

CATHERINE HANCOCK

MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. CARLTON BRINSFIELD

101 DECATUR ST., CUMBERLAND, MD.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>30 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>WADE</b> Last <b>HAMILTON</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>25</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 8, 1915</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RESTURANT OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>	9. AGE (in years last birthday) <b>50 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CRAGEON HAMILTON</b>		14. MOTHER'S MAIDEN NAME <b>JULIA BOGGS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>220 10 1113</b>	17. INFORMANT <b>JULIA M. HAMILTON</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBDURAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CONTUSIONS OF BRAIN</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>9040</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL AT HOME</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9:00</b> p.m. <b>1/20 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>
20f. (City or town) (County) (State) <b>CUMBERLAND ALLEGANY MARYLAND</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		22. DATE SIGNED <b>JAN. 25, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 28, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CEMETERY</b>
23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>		24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>	
25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00033

00033

RECEIVED  
JAN 11 1964  
U.S. DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
BUREAU OF VITAL STATISTICS

DATE OF BIRTH: 11/1/1911  
PLACE OF BIRTH: [illegible]  
SEX: M  
RACE: W  
MARRIAGE: [illegible]

EDUCATION: [illegible]  
OCCUPATION: [illegible]  
MILITARY SERVICE: [illegible]

RELIGION: [illegible]  
MOTHER: [illegible]  
FATHER: [illegible]

DECEASED: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
MARRIAGE: [illegible]

EDUCATION: [illegible]  
OCCUPATION: [illegible]  
MILITARY SERVICE: [illegible]

RELIGION: [illegible]  
MOTHER: [illegible]  
FATHER: [illegible]

DECEASED: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]

X

X

X

X

X

X

X

X

1/1/1911

1/1/1911

CO:

*Charles H. [illegible]*

1/1/1911

1/1/1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					e. STREET ADDRESS <b>582 MC MULLEN HWY</b>				
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>Robert</b> Last <b>HANSEL</b>					4. DATE OF DEATH Month <b>1/4/66</b> Day <b>19</b> Year <b>19</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/27/73</b>		9. AGE (In years last birthday) <b>92</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Agent &amp; Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Hansel</b>					14. MOTHER'S MAIDEN NAME <b>Harriet Troutman</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>PATIENTS CHART Mrs. Margaret E. Hansel</b> <b>582 McMullen Hwy. Cumb.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443x Pulmonary Edema, Cordus Renfermatus</b> DUE TO (b) <b>Renal artery stenosis</b> DUE TO (c) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 3</b> , 19 <b>66</b> , to <b>Jan 4</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Jan 3</b> , 19 <b>66</b> and that death occurred at <b>10</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>DR. B. SCHINDLER</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/4/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>					22d. ADDRESS <b>43 Greene St. Cumberland, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/6/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>		
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>					25a. REC'D BY REGISTRAR <b>JAN 7 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

00000

ALLEGANY

MARYLAND

CUMBERLAND

13 HRS

282 MC MILLER HWY

11/1/55

HANSEL

ROBERT

GEORGE

92

2/27/73

X

WHITE

MALE

PATIENTS CHART

DR. J. SCHINDLER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W.VA.</b> b. COUNTY <b>HAMPSHIRE</b> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MRS. ANNIE M.</b> Middle <b>HARDY</b> Last		4. DATE OF DEATH Month <b>JAN</b> Day <b>15</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/25/86</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>15</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home-maker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES CHESHIRE</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA MICHAEL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>233-74-7100</b>	
17. INFIRMITY <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Labor Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>One week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-10-1966</b> to <b>1-15-1966</b> that (I) (we) last saw the deceased alive on <b>1-15-1966</b> , and that death occurred at <b>11:55 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W.F. Williams</b>		22b. DATE SIGNED <b>1-15-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.F. WILLIAMS</b>		22d. ADDRESS <b>122 S CENTRE ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-18-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Romney, W. Va.</b>	
24. FUNERAL DIRECTOR <b>(c) Byron Light, Cumberland Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			

00032

00032

00032

ALLGANY

CUMBERLAND

MEMORIAL HOSPITAL

MRS. ANNE E. HARDY

F. WHITE

HOME-MADE

JAMES CHESHIRE

MICHAEL

222-7-1111

11-13

DR. W. E. WILLIAMS

122

1-11-00

1-11-00

122

1-11-00



21  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00036

CERTIFICATE OF DEATH

Reg. Dist. No. 00036

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u> 01-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wm. Louis Hans</u>				4. DATE OF DEATH Month Day Year <u>JAN 8 19 66</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15, 1896</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wabash Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Savage</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Perry Hans</u>				14. MOTHER'S MAIDEN NAME <u>Ida James</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>yes World War I</u>		16. SOCIAL SECURITY NO. <u>217-10-1227</u>		17. INFORMANT Address <u>Louis E. Hans - Mt. Savage Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>10 yrs ??</u>						INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetic</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5 JAN.</u> , 19 <u>66</u> , to <u>8 JAN.</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>8 JAN.</u> , 19 <u>66</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>48 BROADWAY</u> DATE SIGNED <u>1/10/66</u>							
ACTUAL SIGNATURE <u>Mark Rothstein M.D.</u>				PHYSICIAN'S NAME (Type) <u>FROSTBURG, MD. 21532</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 11, 1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Savage Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 13 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Philip Judge</u>	



2 1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00037

1. PLACE OF DEATH a. CDUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>D O A</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. CDUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>523 Fayette Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsa</b> Middle <b>Marie</b> Last <b>Henkel</b>		4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 15, 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Canada</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Jules W. Geyer</b>	
14. MOTHER'S MAIDEN NAME <b>Elise Lagrum</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Henry Henkel</b> Address <b>523 Fayette St Cumberland Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4201</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>---</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarellic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		22. DATE SIGNED M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>January 4, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 6, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>John J. Hafer</b>		25a. RECEIVED BY REGISTRAR <b>230 Balto Ave., Cumberland, Md</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00037

00037

Church of Christ

First Baptist Church

First Baptist Church

First Baptist Church

1  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00038

00038

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Klondike*RT. Frostburg</b> c. LENGTH OF STAY IN 1b <b>01-1</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Klondike--R-F-D- Frostburg, MD.</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>HERSICK</b> Last <b>HERSICK</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>23</b> Year <b>1966 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/6/1892</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mike Petron</b>		14. MOTHER'S MAIDEN NAME <b>Mary ----- (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John Hersick, Klondike, RT. Frostburg.</b>		Address <b>(SON)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>9320 EXPOSURE (FREEZING)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DOXOX</b> (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH HOURS HOURS	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>OUTSIDE OF DWELLING <del>WHEN</del> DURING SNOW BLIZZARD</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>5:00</b> am. <b>p.m.</b> <b>Jan 23 19 66</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Near home</b>	20f. (City or town) (County) (State) <b>Klondike, Allegany, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic Cumberland, MD.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/27/1966</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Midland, MD.</b>	
23. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b>		ADDRESS <b>Lonaconing, MD.</b>	
24a. REC'D BY REGISTRAR <b>JAN 26 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

00038

00038

Alfred

Alfred

Alfred

Alfred

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903

1903



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00039 CERTIFICATE OF DEATH					00039				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>109 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>1504 BEDFORD ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MRS. SANDRA A HOFFMAN</b>			First Middle Last		4. DATE OF DEATH <b>JAN. 19, 1966</b>		Day Year		
5. SEX <b>W F</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/10/42</b>		9. AGE (In years last birthday) <b>23</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>COUNTY GOV'T</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN T. TOPPER</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA CAMPBELL</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220 381 2332</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>201X</b> <b>Wadkins Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>36 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19 <b>1-19</b> , 1966, that (I) (we) last saw the deceased alive on <b>1-19</b> 1966, and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>William P James</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/21/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM JAMES</b>				22d. ADDRESS <b>441 N. CENTRE ST. CUMBERLAND, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 22, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>			
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>				ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

00033

00033

ALLEGANY

WYOMING

ALLEGANY

CUMBERLAND

100 DAYS

CUMBERLAND, MD.

MEMORIAL HOSPITAL

JAN. 19, 1966

MRS. SANDRA A. HOFFMAN

MRS.

52

CUMBERLAND

WHITE

U.S.A.

CUMBERLAND, MD.

WILLIAM T. TORRES

WILLIAM T. TORRES

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. WILLIAM JAMES

DR. WILLIAM JAMES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>10 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>						d. STREET ADDRESS <b>107 E. MAIN ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MINNIE</b>			First Middle Last <b>E HOHNG</b>			4. DATE OF DEATH <b>1/27/66</b>			Month Day Year <b>19</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/20/92</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Individual homes</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Mayer</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Horchler</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-05-1358</b>		17. INFORMANT <b>PATIENT'S CHART</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Chronic Anemia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>15 yr.</b> <b>3 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized arthritis and arteriosclerosis</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>None</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>January 3, 1966</b> , to <b>January 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>January 27, 1966</b> , and that death occurred at <b>4:30 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>James F. Hallinan M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-27-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. HALLINAN</b>						22d. ADDRESS <b>140 Bedford St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Janu. 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>			23d. LOCATION (City, town or county) (State) <b>Frostburg, Maryland</b>			
24. FUNERAL DIRECTOR <b>HAVER FUNERAL HOME 60 W. MAIN ST.</b>						25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

• 12 月 11 日 • 1955

DAVIDSON, JAMES HENRY

5/5/5

5

5/10/6

212

Figure 1

• **TX 21**

...and it is not possible to ...

• **Figure 1**

*(continued)*

*Microleptogaster* sp. affinis *M. bifurcata*

groß

576

© 1997 by Cambridge University Press

88 . 72

04-75-1

100-37601-100

THE HALLS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN ID <b>72 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BARTON</b> d. STREET ADDRESS <b>RT. #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>BENJAMIN HYDE</b>			First Middle Last		4. DATE OF DEATH <b>JAN. 29 1966</b>		Month Day Year		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 4, 1895</b>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COAL MINER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MOSCOW, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN HYDE</b>					14. MOTHER'S MAIDEN NAME <b>KATHERINE MOWBRAY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>214-01-3802</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5020</b> <i>Terminal status asthmaticus and Coroner's Order for autopsy</i> DUE TO <b>Arteriosclerotic Cardiovascular disease</b> 10 years (b) DUE TO <b>Chronic bronchitis, asthma, pulmonary fibrosis and emphysema</b> 30 years (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign Hypertrophy Prostate, urinary retention and T.U.R. 16 Dec. 65</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>39 Jan 66</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>18 Jan 65</b> to <b>10:30 P.M.</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>29 Jan 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. Alfred Van Ormer</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>30 Jan. 66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>					22d. ADDRESS <b>122 S. CENTRE ST. CUMB. MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>		23d. LOCATION (City, town or county) (State) <b>Moscow Mills, Md.</b>		
24. FUNERAL DIRECTOR <b>E. J. Boal</b>					ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

00001

00001

ALFRED

MARTIN

ALFRED

MARTIN

75 DAYS

ALFRED

AT 11

MEMORIAL HOSPITAL

00001

AT 11

AT 11

BENJAMIN

AT 11

WHITE

U.S.A.

OSCAR

COAL MINER

KATHERINE

BENJAMIN

MEMORIAL HOSPITAL

AT 11

AT 11

AT 11

122 S. DEARBORN ST. CHICAGO, ILL.

DR. W. A. VAN DYKE

AT 11

*Handwritten signature*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
DR. JACOBSON					CERTIFICATE OF DEATH				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>18 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LONA CONING</b> d. STREET ADDRESS <b>3 HIGH STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>CALVIN</b> Middle <b>C.</b> Last <b>JAMES</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>4</b> Year <b>19 66</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-4-1924</b>		9. AGE (in years last birthday) <b>41</b> yrs. IF UNDER 1 YEAR: Months <b>4</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED - SCHOOL TEACHER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>LONA CONING, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL JAMES</b>				14. MOTHER'S MAIDEN NAME <b>NELLIE BEARD</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>War # 2</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Head of Pancreas with recurrence and extension.</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Obstructive Jaundice</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 28, 1965</b> to <b>Jan. 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan. 3, 1966</b> , and that death occurred at <b>6:05 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <i>Samuel M. Jacobson</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan. 4, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. SAMUEL M. JACOBSON</b>				22d. ADDRESS <b>300 50 PERSHING ST., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/6/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Moscow, MD.</b>			
24. FUNERAL DIRECTOR <b>George Eichhorn</b> ADDRESS <b>Lonaconing, MD.</b>				25a. REC'D BY REGISTRAR <b>IAN 6 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



COPIES

DR. JACOBSON

ALLEGANY

HARLAND

ALLEGANY

18 DAYS

LOHACONING

3 HIGH STREET

MEDICAL HOSPITAL

JANE

C.

ELVIN

JANUARY

HAIR, WHITE

RETIRED SCHOOL TEACHER

BARCEL JAMES

HEB. 12 3039

NEW HOSPITAL - HARLAND, MD.

DR. S.

ALLEGANY

ALLEGANY HOSPITAL - HARLAND, MD.

ALLEGANY

DR. SAMUEL M. JACOBSON

1/6/1900 - Dr. Jacobson

Dr. George Richmond Lohaconing, Dr.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a preliminary certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00043

00043

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>207 Laing Avenue</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles William Johnson</b>				4. DATE OF DEATH Month Day Year <b>Jan. 7 19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1910</b>		9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Rodell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>Mrs. June Twigg Johnson, Cumberland, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO <b>Coronary Sclerosis</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> ----- -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>Jan. 7, 1966</b>	
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M. D.</b>		Address (Street, city, town, or county) <b>Rt. 9, Cumberland</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 10, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mountain View Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sharpsburg, Maryland</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00043

00043

00043

00043

00043

00043

00043

00043

00043

00043

00043

00043

00043

00043

00043

00043

00043

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>1 MONTH</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>924 GREENWOOD ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>FLORENCE A JONES</b> First Middle Last 4. DATE OF DEATH <b>1-25-1966</b> Month Day Year						5. SEX <b>FEM.</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>12-21-1899</b> 9. AGE (In years last birthday) <b>66</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWF. MAID</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>						13. FATHER'S NAME <b>HUGH DARKEY (DEC.)</b> 14. MOTHER'S MAIDEN NAME <b>ANNIE CRABTREE (DEC.)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>217-10-1901</b> 17. CHART <b>CHART</b> Address <b>MD</b>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5400</b> <b>Cardiovascular Hemorrhage</b> DUE TO (b) <b>Acute Left Atrial</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis + Hypertension Heart Disease, old St. Humples</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from <b>12/24, 1965</b> to <b>1/24, 1966</b> , that (I) (we) last saw the deceased alive on <b>1/24, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>S. G. WEISMAN</b> M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>1/25/66</b> 22c. PHYSICIAN'S NAME (Type) <b>S. G. WEISMAN MD</b> 22d. ADDRESS <b>59 GREENE ST CUMBERLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Jan. 27, 1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmont Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>						24. FUNERAL DIRECTOR <b>John J. Hafer</b> ADDRESS <b>230 Balto Ave., Cumberland, Md</b> 25a. REC'D BY REGISTRAR <b>1/28/66</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>					

00044

ALLEGANY

MARYLAND

CUMBERLAND

1 MONTH

CUMBERLAND

SACKED HEART HOSPITAL

254 GREENWOOD ST.

1-22-1960

JONES

A

FLORENCE

66

12-21-1959

X

WHITE

FBI

U.S.

MARYLAND

W.F.

(DEC.)

(DEC.)

CHART

12-21-1959

Handwritten notes and signatures at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u> c. LENGTH OF STAY IN 1b <u>17 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MINERS HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u> d. STREET ADDRESS <u>86 BROADWAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>ANNIE M. KENNEY</u> First Middle Last 4. DATE OF DEATH <u>JAN. 25th 1966</u> Month Day Year					9. AGE (in years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOUSEWORK</u>					11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>ANGUS MCATEE</u>					14. MOTHER'S MAIDEN NAME <u>CATHERINE FARRELL</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>					16. SOCIAL SECURITY NO. <u>LEONARD KENNEY</u> 17. INFORMANT <u>86 BROADWAY, FROSTBURG, MD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio sclerosis</u> <u>4500</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 30</u> , 19 <u>65</u> to <u>Jan 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 25</u> , 19 <u>66</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>W. O. McLane</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>W. O. McLane</u> " 22d. ADDRESS <u>167 E. MAIN ST., FROSTBURG, MD.</u> 22b. DATE SIGNED <u>Jan 28 1966</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>1-28-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAELS CEMETERY</u> 23d. LOCATION (city, town or county) (State) <u>FROSTBURG, MD.</u>									
24. FUNERAL DIRECTOR <u>JOSEPH R. DURST, SR.</u> ADDRESS <u>FROSTBURG, MD.</u> 25a. REC'D BY REGISTRAR <u>FEB 1 1966</u> 25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>									

00000

00012

James 11/14



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00016

01578

1. PLACE OF DEATH e. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b>		d. STREET ADDRESS <b>Parkersburg Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Parkersburg Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Albert</b> Last <b>Klosterman</b>				4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 15, 1914</b>	9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>01</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Preparation Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Vale Summit, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Klosterman</b>				14. MOTHER'S MAIDEN NAME <b>Rhoda Yeider</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-07-0967</b>		17. INFORMANT Address <b>Eckhart, Md.</b> <b>Mrs. Thomas Klosterman, Parkersburg Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <b>5020</b> DUE TO <b>COR PULMONALE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>PULMONARY EMPHYSEMA</b> DUE TO <b>CHRONIC BRONCHITIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 YRS</b> <b>20 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 1965, to <b>30 JAN</b> , 1966, that (I) (we) last saw the deceased alive on <b>28 JAN</b> , 1966, and that death occurred at <b>9A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Michael Glick, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>L. Michael Glick, M.D.</b>				22d. ADDRESS <b>126 N. Smallwood St., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 2, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HAFER FUNERAL HOME, 60W. MAIN ST.</b>				25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

45214

• 324 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>57 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL, MEM. AVE.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b> d. STREET ADDRESS <b>RT. 1, BOX 136-A</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HENRY E. LARUE</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>11</b> Year <b>1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>12-2-1883</b>		9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (County & State, or foreign country) <b>GARRETT CO. MD.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>CHARLES LARUE</b>					
14. MOTHER'S MAIDEN NAME <b>MATILDA MCKENZIE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>					
16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic and terminal congestive heart failure 2nd.</b> <b>5230</b> DUE TO (b) <b>A. S. Cardiovascular disease</b> DUE TO (c) <b>Chronic pulmonary fibrosis and emphysema</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ischemic heart disease, previous, secondary to atherosclerosis.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10:59 am</b> <b>11 Jan, 1966</b> , that (I) (we) last saw the deceased alive on <b>10 Jan. 1966</b> , and that death occurred at <b>4:40 AM</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Alfred Van Ormer</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>				22d. ADDRESS <b>122 S. CENTRE ST.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>			
23d. LOCATION (City, town or county) <b>Westernport</b>		(State) <b>MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>			
24. FUNERAL DIRECTOR <b>Ed Bual</b>		ADDRESS <b>Westernport, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

MEDICAL CERTIFICATION

30028

00022

FRANKLIN

WESTERN

ST. J. BOX 100-1

JANUARY 11 1966

10-1-66

MAILING SERVICE

GENERAL HOSPITAL, TONKIN AND, MO.

DR. W. A. VAN COTTEN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00048 CERTIFICATE OF DEATH 00047									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. LENGTH OF STAY IN 1b <b>3 DAYS</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					e. STREET ADDRESS <b>212 W. OLDTOWN ROAD</b>				
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>W.</b> Last <b>LECHLITER</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>19</b> Year <b>1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>X</b>		8. DATE OF BIRTH <b>6-17-1902</b>		9. AGE (In years last birthday) <b>63</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND - CUMBERLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM LECHLITER</b>					14. MOTHER'S MAIDEN NAME <b>IRENE PAINTER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>War II</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Thrombocytopenia</b> DUE TO (b) <b>Left Cerebral Hemorrhage</b> DUE TO (c) <b>Right Hemiplegia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>5 day</b> <b>5 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1966</b> to <b>Jan 19, 1966</b> that (I) (we) last saw the deceased alive on <b>Jan 19, 1966</b> , and that death occurred at <b>2:03 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Clay E. Durrett</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>1/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>					22d. ADDRESS <b>236 VIRGINIA AVE., CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 21, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>JAN 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

00007

00008

LIBRARY

NEWLAND

ALL TOOK

CHURCHLAND

3 DAYS

CHURCHLAND

IS B. OLDEN ROAD

RECTORIAL HOSPITAL

JAN 1907

W. L. HILL

ALBERT

25

2-3-1907

WHITE

WILE

U.S.

WILSON

HOME

THREE-PAINTED

MILITARY REGIMENT

THE HOSPITAL - CHURCHLAND, N.Y.



COLLECTED

DR. J. W. B. BROWN

WILSON - NEWLAND, N.Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
DR. MILLER					CERTIFICATE OF DEATH					00048	
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>11 RIDGEWAY TERRACE</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>B.</b> Last <b>LEMMERT</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>5</b> Year <b>19 66</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-7-1899</b>		9. AGE (in years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MT. SAVAGE, MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>KILLIOUS FOLK</b>					14. MOTHER'S MAIDEN NAME <b>MARY LOGSDON</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>blind eye with secondary glaucoma</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> , 19 <b>65</b> , to <b>1/5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/5</b> , 19 <b>66</b> , and that death occurred at <b>4:20</b> M. from the causes and on the date stated above.											
22a. SIGNATURE <b>David H. Miller</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/6/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>DR. DAVID H. MILLER</b>					22d. ADDRESS <b>22 WASHINGTON ST., CUMBERLAND, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-7-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. George Episcopal</b>			23d. LOCATION (City, town or county) (State) <b>Mt. Savage, Md.</b>				
24. FUNERAL DIRECTOR <b>Joseph R. Dunst, Jr., Frostburg, Md.</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

00000

DR. MILLER

ALL BOOBY

CUMBERLAND

HOSPITAL HOSPITAL

ADA

B.

LEWIS

JANUARY

REVIEW WHITE

HOUSEHOLD

WILLIAMS FOLK

HOSPITAL HOSPITAL

*Handwritten signature*

*Handwritten signature*

DR. DAVID H. MILLER

WASHINGTON ST. CUMBERLAND, MD.

00000

ALL BOOBY

CUMBERLAND

2 DAYS

CUMBERLAND

11 RIDGEWAY TERRACE

JANUARY

REVIEW WHITE

HOUSEHOLD

WILLIAMS FOLK

HOSPITAL HOSPITAL

*Handwritten signature*

*Handwritten signature*

DR. DAVID H. MILLER

WASHINGTON ST. CUMBERLAND, MD.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT. M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00050  
MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
00049

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT#2 FLINTSTONE</b>		c. LENGTH OF STAY IN 1b <b>46 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT#2 FLINTSTONE</b>	
		f. STREET ADDRESS <b>01-1</b>	
3. NAME OF DECEASED (Type or print) <b>EMMA ISABELL MALLOW</b>		4. DATE OF DEATH <b>JAN. 28 1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27 1917</b>
9. AGE (In years last birthday) <b>48 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
12. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		13. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14. FATHER'S NAME <b>James Twigg</b>		15. MOTHER'S MAIDEN NAME <b>Oka (McElfish) Twigg</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>214-07-0085</b>	
18. INFORMANT <b>Alston French Mallow</b>		19. ADDRESS <b>RT#2 Flintstone, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, GENERALIZED</b> <b>1530</b> DUE TO (b) <b>CARCINOMA OF RIGHT COLON</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b> <b>3 years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24. EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, MD</b>		25. DATE SIGNED <b>JAN. 28, 1966</b>	
26. ADDRESS (Street, city, town, or county) <b>Cumberland, Md.</b>			
27a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		27b. DATE THEREOF <b>31 Jan 66</b>	
27c. NAME OF CEMETERY OR CREMATORY <b>GLENDALE CEMETERY</b>		27d. LOCATION (City, town or county) (State) <b>FLINTSTONE MD</b>	
28. FUNERAL DIRECTOR <b>H. Lee Silcox</b>		29. ADDRESS <b>Cumberland, Maryland</b>	
30. REC'D BY REGISTRAR <b>FEB 2 1966</b>		31. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00000

00000

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VR AISME (5)  
SM 1/65

## 00051

10051

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale</b>		c. LENGTH OF STAY IN 1b <b>D O A</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>21 National Highway</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Andrew</b> Last <b>Martz</b>		4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1896</b>
9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Motor Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Streetts Body Works</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Martin Martz</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Marley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W W 1</b>	
17. INFORMANT <b>Mrs. Margaret Martz, 21 Nat'l Hwy, La Vale Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION, LEFT</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>----</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>January 23, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 26, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sts. Peter &amp; Paul's Cem</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland, Md</b>
24. FUNERAL DIRECTOR <b>John J. Haler</b>		25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

00000

00001

EXAMINER'S CERTIFICATE OF DEATH

General and Hospital

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...

George W. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP-

VR A15 (4)  
20M 1/65

00052

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
DR. JAMES

CERTIFICATE OF DEATH

00051

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>21 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LA VALE,</b> d. STREET ADDRESS <b>12 CASH VALLEY ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>LUCILLE</b> Last <b>MATLICK</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-2-1893</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS JONES</b>		14. MOTHER'S MAIDEN NAME <b>EMMA VALENTINE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. Thomas Matlick</b>		Address <b>Cash Valley Rd. MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Congestive Heart Failure</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus, Kimmelstiel Wilson Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19 to <b>1-30</b> , 1966, that (I) (we) last saw the deceased alive on <b>1-30</b> 1966, and that death occurred at <b>12:01 A.M.</b> on, from the causes and on the date stated above.			
22a. SIGNATURE <b>William P. James</b>		22b. DATE SIGNED <b>1/31/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM P. JAMES</b>		22d. ADDRESS <b>441 N. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/2/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>Feb 4 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00052

00051

DR. JAMES

ALLEGANY

ALLEGANY

MARYLAND

CUMBERLAND

21 DAYS

LA VALE

MEMORIAL HOSPITAL

12 CASH VALLEY ROAD

ANNA

LUCILLE

WATKIN

JANUARY 30

66

FEMALE WHITE

10-5-1923

72

HOUSEWIFE

CUMBERLAND, MD.

U.S.A.

LOUIS JONES

EMMA VALENTINE

MEMORIAL HOSPITAL CUMBERLAND, MD.

*[Handwritten signature]*

12:01 A.M.

DR. WILLIAM P. JAMES

401 N. CENTRE ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00053 CERTIFICATE OF DEATH 00052

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>16 DAYS</b>		d. STREET ADDRESS <b>632 SHRIVER AVE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALEXANDER</b> Middle <b>Gibson</b> Last <b>MC CRORIE</b>		4. DATE OF DEATH Month <b>1/4/66</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/90</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Eagles Lodge Rms.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Lonaconing, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John McCrorie</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Gibson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-10-0121</b>	
17. INFORMANT <b>Mrs. Bertha McCrorie</b> Address <b>632 Shriver Ave. Cumb. Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>carcinomatous of lungs</b> 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>12-19-</b> , 19 <b>65</b> , to <b>1-4-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-3-</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Legis. Brings</b>		22b. DATE SIGNED <b>1-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. L. BRINGS</b>		22d. ADDRESS <b>57 Greene St. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/6/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

00028

ALLEGANY

MARYLAND

CUMBERLAND

12 DAYS

CUMBERLAND

632 SHRIVER AVE

SACRED HEART HOSPITAL

14486

MC CORMACK

ALEXANDER

75

2/10/90

WHITE

MALE

PATIENT'S CHART

200-1-101

DR. L. BRINGS

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>4 Months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>York Hotel, Balto &amp; Henderson Aves</u>		d. STREET ADDRESS <u>246 1/2 N. Centre St</u>	
3. NAME OF DECEASED (Type or print) <u>Charles R. McDonough</u>		4. DATE OF DEATH <u>January 12 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1902</u>
9. AGE (In years last birthday) <u>63 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Robert McDonough</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Berkenbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>220-07-6892</u>	
17. INFORMANT <u>Florence Rohrer</u>		Address <u>127 Union St., Cumberland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>CORONARY OCCLUSION</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		22. DATE SIGNED <u>January 12, 1966</u>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 15, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Catholic Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>
24. FUNERAL DIRECTOR <u>John J. Stafer</u>		25a. REC'D BY REGISTRAR <u>MAN 18 1956</u>	
ADDRESS <u>230 Balto Ave. Cumberland,</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00052

00052

THE UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]  
DATE: [Illegible]  
[Illegible text]

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

00

2

BP 2

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>00055</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>00054</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Lonaconing</b>				c. LENGTH OF STAY IN 1b <b>01-1</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Lonaconing</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Harpersville</b>				d. STREET ADDRESS <b>Harpersville</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RUTH JANE McFarlane</b>				4. DATE OF DEATH <b>1/10/1966</b>				5. SEX <b>Female</b>			
6. COLOR OR RACE <b>White</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>7/15/1894</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>(Ocean) RD. Frostburg, MD. USA</b>			
13. FATHER'S NAME <b>William Wellings</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Yates</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Paul McFarlane</b> Address <b>Lonaconing, MD. RD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM, MASSIVE</b> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <b>ULCERATIONS AND EDEMA OF LOWER EXTREMITIES, DIABETIC</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>  <b>YEARS</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frostburg, MD.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, Cumberland, MD.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>1/10/1966</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/13/1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Frostburg, MD.</b>			
23. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b>				ADDRESS <b>Lonaconing, MD.</b>				24a. REC'D BY REGISTRAR <b>JAN 13 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



BUOBA

00057

AMERICAN EXHIBIT

10-11-1930

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

Allegations

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN ID <b>13 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> <b>01-1</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>						d. STREET ADDRESS <b>ROUTE 4 BOX 1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>			First <b>JOHN</b> Middle <b>J.</b> Last <b>MILKOWSKI</b>			4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>19 66</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 12, 1897</b>		9. AGE (in years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Eckhart, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Andrew Milkowski</b>						14. MOTHER'S MAIDEN NAME <b>Katherine Tylock</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>705-05-4563</b>		17. INFORMANT <b>PATIENT'S CHART</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hemorrhage and hematoma</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unknown causes; possible slight head injury during an Adams-Stokes attack</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac enlargement; recent (Nov 1965) congestive failure &amp; infarction</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>November</b> , 1965, to <b>Jan. 27</b> , 1965 that (I) (we) last saw the deceased alive on <b>January 26</b> , 1965, and that death occurred at <b>12:45</b> , from the causes and on the date stated above.											
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) <b>Wyand F. Doerner, Jr., M.D.</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>January 28, 1965</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE 			

00055

00055

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

13 DECEMBER 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> <span>00057</span> <span>Item #14 Film #4373 2/10/66 pg</span> <span>00056</span> </div>											
1. PLACE OF DEATH a. COUNTY <b>ALEEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALEEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLDTOWN</b> d. STREET ADDRESS <b>RT. #1,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>JEANETTE ELSIE NEWLON</b>						4. DATE OF DEATH Month Day Year <b>JAN. 13 19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-12-66</b>		9. AGE (In years last birthday) yrs. <b>13</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. NEWLON</b>						14. MOTHER'S MAIDEN NAME <b>ROSALEE WHITE Betson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> <b>7545</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>CONGENITAL HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <i>Robert D. Brodell</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-15-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. ROBERT D. BRODELL</b>						22d. ADDRESS <b>500 EMM GREENE ST. CUMB. MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>1-17-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital</b>				23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>			
24. FUNERAL DIRECTOR <i>John A. M. Hardy</i>				ADDRESS <b>Memorial Hospital, Cumberland, Md</b>		25a. REC'D BY REGISTRAR <b>JAN 21 1966</b>		25b. REGISTRAR'S SIGNATURE <i>John A. Judge</i>			

6-168858

00055

00055

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-15-01 BY 60322X/STC/STC

OLDTOWN

1 DAY

CUNEBOLAND

MEMORIAL HOSPITAL

RT. 01

NEW OR

ELITE

JEANETTE

1-15-

REAR WHITE

CONCRETE

REAR WHITE

JOHN T. NEWTON

MEMORIAL HOSPITAL

CARDINAL FAIR

CONCRETE

DR. ROBERT A. GRODINS

60322X/STC/STC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

00058

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00057

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. LENGTH OF STAY IN 1b <u>45 Yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		d. STREET ADDRESS <u>419 Md. Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>419 Md. Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Rhea</u> Middle <u>Niland</u> Last		4. DATE OF DEATH <u>Jan.</u> <u>9</u> <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1891</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Allegany-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Ida C. Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Catherine Niland-Westernport</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 month</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>61</u> , to <u>1-9-</u> , 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>1-7</u> , 19 <u>66</u> , and that death occurred at <u>11</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>William W. Lesh</u>		22b. DATE SIGNED <u>1-10-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William W. Lesh</u>		22d. ADDRESS <u>Westernport, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/12/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>		23d. LOCATION (City, town or county) (State) <u>Westernport Md.</u>	
24. FUNERAL DIRECTOR <u>E. J. Boral</u>		25a. REC'D BY REGISTRAR <u>JAN 13 1966</u>	
ADDRESS <u>Westernport, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



00000

00000

1971

1971

1971



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00059					00058				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Allegany</b>					a. STATE <b>Maryland</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>					b. COUNTY <b>Allegany</b>				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>63 1/2 East Main Street</b>					d. STREET ADDRESS <b>63 1/2 East Main Street</b>				
3. NAME OF DECEASED (Type or print) <b>Alexander Patton</b>					4. DATE OF DEATH <b>January 12 1966</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <b>August 15, 1906</b>				
9. AGE (In years last birthday) <b>59</b> yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>County Home Employee</b>					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <b>Lonaconing, Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Alexander Patton</b>					14. MOTHER'S MAIDEN NAME <b>Ella Brown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO.				
17. INFORMANT <b>Alex E. Patton</b>					Address <b>Lonaconing, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 12, 1966</b> to <b>Jan 12, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 12, 1966</b> , and that death occurred at <b>7 p.m.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Leslie R. Miles</b>					22b. DATE SIGNED <b>1/13/1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Leslie R. Miles</b>					22d. ADDRESS <b>Lonaconing, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>1/15/1966</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>					23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b>				
24. FUNERAL DIRECTOR <b>George Eichhorn</b>					25a. REC'D BY REGISTRAR <b>JAN 14 1966</b>				
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

00058

## CERTIFICATE OF DEATH

00058

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. FREDERICK STREET, BALTIMORE 1, MARYLAND

All Agency

Maryland

All Agency

Longmont

62 Year and 3 Months

62 Year and 3 Months

Alexander

Landon

January 19 1946

January 15, 1906 39

County Home Employee

Longmont, Maryland

Alexander Person

Miss

Alex S. Person

Longmont, Md.

Person

DATE OF BIRTH: 1906 JAN 15  
 PLACE OF BIRTH: LONGMONT, MARYLAND  
 SEX: F  
 RACE: WHITE  
 COLOR: WHITE  
 HEIGHT: 5 FT 10 IN  
 WEIGHT: 125 LB  
 BUILD: SLIM  
 EYES: BLUE  
 HAIR: BROWN  
 COMPLEXION: FAIR  
 TENDENCY: NONE

Leslie A. Miller

Longmont, Md.

January 15, 1906

George Johnson

Longmont, Md.

b.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>519½ MEMORIAL AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>PEARL</b> Last <b>PERRIN</b>			4. DATE OF DEATH Month <b>JAN.</b> Day <b>26</b> Year <b>1966</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 3, 1885</b>		9. AGE (In years last birthday) <b>80</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Registered Nurse.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY PERRIN</b>					14. MOTHER'S MAIDEN NAME <b>AMY ROBINETTE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>214-32-3340</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Mesenteric Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Many years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>Less than 1 day.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>3:35</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1-24-1966</b> that (I) (we) last saw the deceased alive on <b>1-26-1966</b> and that death occurred at <b>3:35 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>W. F. Williams</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-27-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>					22d. ADDRESS <b>122 S. CENTRE ST. CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/31/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>		
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b> <b>Cumberland, Maryland 21502</b>					25a. REC'D BY REGISTRAR <b>FEB 1 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

00000

00000

ALLEGANY

ALLEGANY

CUMBERLAND

CUMBERLAND

2 DAYS

214 MEMORIAL AVE.

MEMORIAL HOSPITAL

LEERIN F. H. JAN.

LILLIE

AUG. 2, 1925

FEMALE WHITE

U.S.A.

HENRY D.

AMY COBINETTE

HENRY DERRIN

MEMORIAL HOSPITAL

DR. W. F. WILLIAMS

WILLIAMS

WILLIAMS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00061					00060				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY					b. COUNTY				
ALLEGANY					MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b				
CUMERLAND					14 HRS. 15 MIN.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
MEMORIAL HOSPITAL					88 W. MECHANIC ST.				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
BABY BOY PETENBRINK					JAN. 10 19 66				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		JAN. 10, 1966		4 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			
						CUMBERLAND, MD.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
RONALD PETENBRINK					VIOLA E. JOHNSON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT			
						MEMORIAL HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								14 1/2 hrs	
IMMEDIATE CAUSE (a) Prematurity									
776 X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from Jan 10, 1966, 7:15 to P.M., 1966, that (I) (we) last saw the deceased alive on Jan 10, 1966, and that death occurred at 7 M, from the causes and on the date stated above.									
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
DR. RALPH A. REITER								Jan. 11, 1966	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
DR. RALPH A. REITER						112 BEDFORD ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			Jan. 11, 1966		Porter Cemetery		Frostburg Maryland		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR						
J. St. Mattingly			FROSTBURG, MD.						
HAVER FUNERAL HOME, 60 W. MAIN ST.			DATE JAN 14 1966						
			25b. REGISTRAR'S SIGNATURE						
			J. Charles Judge						

6-168844

00000

00001

MARYLAND

ALBANY

FROSTBURG, MD.

COLEMAN

30 W. MECHANIC ST.

MEMORIAL HOSPITAL

JAN. 10

PETERBRIK

BOY

BABY

JAN. 10, 1966

MALE WHITE

CUMBERLAND, MD. U.S.A.

WILDA E. JOHNSON

RONALD PETERBRIK

MEMORIAL HOSPITAL

7:15 P.M.

DR. RALPH A. REITER

12 BEDFORD ST. CUMBERLAND, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00062						00061							
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>45 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				01-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						d. STREET ADDRESS <b>9 RACE ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MRS. MARGARET PLUMMER</b>			First Middle Last			4. DATE OF DEATH Month Day Year <b>JAN. 16 19 66</b>							
5. SEX <b>F</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/8/16</b>		9. AGE (In years last birthday) <b>49</b>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ALLEGANY CO. MARYLAND U S A.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>				
13. FATHER'S NAME <b>RUSSELL BENFORD Bedford</b>						14. MOTHER'S MAIDEN NAME <b>DANBY-THERESA -Catherine Danahy</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>mp</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL,, CUMBERLAND, MD.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>241x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic asthma</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>40 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture, neck, left femur</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Fall at home</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>12/2/1965</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland Md. Md</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>2 Dec, 1965</b> , to <b>16 Jan, 1966</b> , that (I) (we) last saw the deceased alive on <b>16 Jan, 1966</b> , and that death occurred at <b>1:25 PM</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Robert F. Feddis</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>21 Jan 66</b>					
22c. PHYSICIAN'S NAME (Type) <b>DR. ROBERT FEDDIS</b>						22d. ADDRESS <b>500 GREENE ST. CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Jan. 19, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>					
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>JAN 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



00001

00002

ALLEGANY

HARYARD

ALLEGANY

CUMBERLAND

12 DAYS

CUMBERLAND

3 RACE ST.

MEMORIAL HOSPITAL

65

100.10

MRS. MARGARET FLORENCE

43

30.10

WHITE

F

ALLEGANY CO. HARYARD U. S. A.

DANIEL THOMAS

RUSSELL BENJAMIN

MEMORIAL HOSPITAL, CUMBERLAND, MD.

500 GREENE ST. CUMBERLAND, MD.

DR. ROBERT FROST

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>Lonaconing 01-1</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>					d. STREET ADDRESS <b>Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Elsie</b>			First Middle Last <b>Rankin</b>			4. DATE OF DEATH Month Day Year <b>January 17 19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 18, 1898</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	IF UNDER 48 HRS.	IF UNDER 72 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>South Fork, Pa</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles W. Hoffa</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Young</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>William Rankin Lonaconing, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> <b>330X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , to <b>Jan 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 16, 1966</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>L.R. Miles Jr MD</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1.17.66</b>		
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES JR MD</b>					22d. ADDRESS <b>Lonaconing Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/19/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>			23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b>		
24. FUNERAL DIRECTOR <b>George Eichhorn</b>					25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Chisley Judge</b>		

WASH STATE DEPARTMENT OF HEALTH

VOLUME 11A

61215

Figure 2

— *John Barron*

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00064

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00063

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. LENGTH OF STAY IN 1b <b>01-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>State Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Rankin</b> Last <b>Rankin</b>				4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 21, 1893</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>LONA CONING, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John Thomas</b>			
14. MOTHER'S MAIDEN NAME <b>Ora Thomas</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs. John Skockey</b> Address <b>Lonaconing, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> 4201 DUE TO <b>Atherosclerotic CV Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>years</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>Jan. 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan. 15, 1966</b> , and that death occurred at <b>4 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L.R. Miles, Jr.</b>						22b. DATE SIGNED <b>1/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>				22d. ADDRESS <b>LONA CONING MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Moscow, Md.</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>				25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00065

00064

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>RT.#2, WILLIAMS ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE E. RAVENSCROFT</b>		First Middle Last		4. DATE OF DEATH <b>JANUARY 17 1966</b>		Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-1909</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>KEYSER, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>COLUMBUS RAVENSCROFT</b>				14. MOTHER'S MAIDEN NAME <b>ANN ERVIN (Annie)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>217-09-2411</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Shock</b> <b>5810</b> DUE TO (b) <b>Bleeding Esophageal Varices</b> DUE TO (c) <b>Hepatic Cirrhosis</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/14</b> , 19 <b>66</b> , to <b>1/17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> , 19 <b>66</b> , and that death occurred at <b>20 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leo H. Ley Jr.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEO H. LEY</b>				22d. ADDRESS <b>456 N. CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 20, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Johnas Judge</b>	

00000

00000

ALLEGANY

ALLEGANY

ALLEGANY

CUMBERLAND

2 DAYS

CUMBERLAND

BT. 42, WILLIAMS ROAD

MEMORIAL HOSPITAL

JANUARY 13 1964

E. RAVENSCROFT

GEORGE

12-17-1964

MALE WHITE

U.S.A.

KEYSER, W.VA.

COLONOUS RAVENSCROFT

WV. 17-12-64

MEMORIAL HOSPITAL, CUMBERLAND, MD.

1:25 PM

LEO H. LEY

450 N. CHURCH ST., C. BERLAND, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>26 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>224 WASHINGTON ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>MRS. ELIZABETH C. RICHARDSON</b> First <b>Elizabeth</b> Last <b>Richardson</b>			<b>4. DATE OF DEATH</b> <b>JAN 29, 19 66</b> Month <b>Jan</b> Day <b>29</b> Year <b>19 66</b>		<b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>1/12/15</b> <b>9. AGE</b> (In years last birthday) <b>51</b> yrs. IF UNDER 1 YEAR: Months <b>01</b> Days <b>1</b> IF UNDER 24 HRS: Hours <b>01</b> Min. <b>00</b>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Teacher</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Education</b>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Arkansas City KANSAS</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A</b>		<b>13. FATHER'S NAME</b> <b>FREDERICK GOULD</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>HELEN TOPP</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <b>707-12-9731</b>		<b>17. INFORMANT</b> <b>Rev. H. M. Richardson</b> Address <b>224 Washington</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD. St.</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphoma - primary site</b> DUE TO <b>2002</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Supraclavicular glands - left</b> DUE TO <b>of '61</b> (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Fall 1961</b> , 19 <b>to 1-29-1966</b> , that (I) <b>and</b> last saw the deceased alive on <b>1-28-1966</b> and that death occurred at <b>7:40 AM</b> from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <b>Dr. W.F. Williams</b> M.D.					<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>1-30-66</b>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>DR. W.F. WILLIAMS</b>					<b>22d. ADDRESS</b> <b>122 S. CENTRE ST. CUMBERLAND, MD.</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>2/1/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Cumberland, Maryland</b>		
<b>24. FUNERAL DIRECTOR</b> <b>H. Wayne George</b> <b>Cumberland, Maryland</b>					<b>25a. REC'D BY REGISTRAR</b> <b>FEB 4 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>		

00000

00000

ALLEGANY

CHERRYLAND

CHERRYLAND

220 WASHINGTON ST.

MEMORIAL HOSPITAL

JAN 22, 1968

ELIZABETH RICHARDSON

WHITE

FEMALE

U.S.A.

HELEN TO LIFE

FREDERICK GOULD

MEMORIAL HOSPITAL, CHERRYLAND, MD.

DR. W.F. WILLIAMS

122 S. GENTLE ST., CHERRYLAND, MD.

FOR STATE  
HEALTH DEPT.

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00067

00066

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
c. LENGTH OF STAY IN 1b <b>44 years</b>		d. STREET ADDRESS <b>1404 Virginia Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>K.</b> Last <b>Rinehart</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>12</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1921</b>
9. AGE (In years last birthday) <b>44 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Ruble</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Wasbaugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mr. James Ruble, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Bilateral</b> <b>9160</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Burns and Inhalation</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>14 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Cigarette Fire while asleep</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:30 p.m. Dec. 31 1965</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland, Allegany, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>Jan. 12, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Rt. 9, Cumberland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 15, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 17 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

00000

00000

THE STATE OF TEXAS,  
COUNTY OF DALLAS,  
I, the undersigned, Clerk of the County Court,  
do hereby certify that the within and foregoing  
is a true and correct copy of the original  
as the same appears from the records of the  
County Court of Dallas County, Texas.

Witness my hand and the seal of the County Court  
at Dallas, Texas, this 1st day of January, 1900.

CLERK OF COUNTY COURT,  
DALLAS COUNTY, TEXAS.

10:30 P.M. J. J. [Signature]  
[Signature]  
[Signature]

Notary Public for Texas,  
Dallas County, Texas.  
[Signature]  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 00068 CERTIFICATE OF DEATH 00067														
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1 HR.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> 01-1									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>510 LINDEN ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>VIOLA</b>		First <b>VIOLA</b>		Middle <b>M.</b>		Last <b>ROWAN</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>31</b> Year <b>1966</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-17-1899</b>		9. AGE (In years last birthday) <b>66</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>CLARENCE SPIDELL</b>					14. MOTHER'S MAIDEN NAME <b>JENNIE BOYER</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> 4201 DUE TO (b) <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Myocardial Infarction</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Church Alley Md</b>		20f. (City or town) (County) (State) <b>Cumberland Md</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>1/12/60</b> , 19 to <b>1/31/66</b> , 19, that (I) (we) last saw the deceased alive on <b>12/20/65</b> , 19, and that death occurred at <b>4:35 AM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/3/66</b>									
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>			22d. ADDRESS <b>122 S. CENTRE ST.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 3, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>							
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>Feb 7 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

00007

00007

ALLEGHANY

MARYLAND

ALLEGHANY

CUMBERLAND

1 HR.

CUMBERLAND

210 LINDEN ST.

MEMORIAL HOSPITAL

JANUARY 31 1888

ROMAN

VIOLA

6 12-1888

FEMALE WHITE

U. S. A.

MARYLAND

JENNIE BOYER

CLARENCE SPIDELL

MEMORIAL HOSPITAL, CUMBERLAND, MD.

*Handwritten notes:*  
Cumberland Hospital  
Cumberland, Md.

*Handwritten notes:*  
Cumberland Hospital  
Cumberland, Md.

*Handwritten notes:*  
Cumberland Hospital  
Cumberland, Md.

122 S. CENTRE ST.

DR. R. J. WILLIAMS

*Handwritten notes:*  
Cumberland Hospital  
Cumberland, Md.

*Handwritten notes:*  
Cumberland Hospital  
Cumberland, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

00069

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00068

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>13 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>406 YORK ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MR, GEORGE P. SCHADE</b>			4. DATE OF DEATH Month Day Year <b>JAN 2 19 66</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/30/93</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND - CUMBERLAND</b>			
13. FATHER'S NAME <b>HENRY SCHADE</b>			14. MOTHER'S MAIDEN NAME <b>ANNA B. MAHAN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-05-9062</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Left Cerebral Hemorrhage</b> DUE TO (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>6 days</b> <b>6 yrs</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 1959</b> to <b>Jan 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 2 19 66</b> , and that death occurred at <b>1.17 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clayton Durrett</b>				22b. DATE SIGNED <b>1/3/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. CLAY DURRETT</b>		22d. ADDRESS <b>VIRGINIA AVE. CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 5, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>			
23d. LOCATION (City, town or county) <b>Cumberland, Md.</b>		(State)					
24. FUNERAL DIRECTOR <b>James F. Scarpellik Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 7 1966</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



00000

00000

ALBANY

MARY AND

ALBANY

CUMBERLAND

10 DAYS

CUMBERLAND

MEMORIAL HOSPITAL, MEMORIAL AVE., 408 YORK ST.

GEORGE E. SCHADE

MR.

11/30/23

WHITE

U.S.A.

AND

ANNA E. KAHN

HENRY SCHADE

MEMORIAL HOSPITAL, CUMBERLAND, MD.

VIRGINIA AVE. CUMBERLAND, MD.

DR. C.W. DURETT

FILED IN RECORD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																					
<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>4 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYNDMAN, PA.</b> d. STREET ADDRESS <b>75 - 3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MARY</b> Middle <b>M.</b> Last <b>SCHUHWERK</b>			<b>4. DATE OF DEATH</b> Month <b>JAN.</b> Day <b>10</b> Year <b>1966</b>		<b>5. SEX</b> <b>FEMALE</b>			<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>											
<b>8. DATE OF BIRTH</b> <b>SEPT. 2, 1880</b>			<b>9. AGE</b> (In years last birthday) <b>85</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MT. SAVAGE, MD.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>13. FATHER'S NAME</b> <b>GEORGE WITT</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY MARTHA</b>																
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL</b>		<b>Address</b>														
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cardiac failure</b> 443X DUE TO (b) <b>A.S. and Hypertensive Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 weeks</b> <b>5 years.</b>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Pneumonitis, left lower lobe, C. U.</b>																					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)														
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>6 Jan. 1966</b> , <b>10:50 A.M.</b> , <b>1966</b> , that (I) (we) last saw the deceased alive on <b>10 Jan. 1966</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.																					
<b>22a. SIGNATURE</b> <b>W. Alfred Van Ormer</b>					<b>22b. DATE SIGNED</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. W.A. VAN ORMER</b>		<b>22d. ADDRESS</b> <b>122 S. CENTRE ST. CUMB. MD.</b>												
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>January 13, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Palo Alto Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Hyndman, Pa. RD#1</b>														
<b>24. FUNERAL DIRECTOR</b> <b>Harvey H. Zeigler</b>					<b>25a. REC'D BY REGISTRAR</b> <b>JAN 17 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>														

00000

00000

RECEIVED

PENNSYLVANIA

HYNDEN, PA.

4 DAYS

CONFERRED

ALLEGANY

MEMORIAL HOSPITAL

HARRY

FEMALE WHITE

SEPT. 2, 1980

MT. SAVAGE, MD.

HARRY WHITE

RECORD WITH

MEMORIAL HOSPITAL

*Transmitted to the following  
A 2 at Hyndes Memorial Hospital*

*Transmitted, off line, late, C. A.*

*8:10 PM 10:20 A.M.*

*W. J. [unclear] [unclear]*

*10:20 PM 10:20 A.M.*

*Transmitted to the following  
A 2 at Hyndes Memorial Hospital*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN ID <b>28 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>HARDY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MOOREFIELD</b> d. STREET ADDRESS <b>85-3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>CONWAY</b> Middle <b>W.</b> Last <b>SCOTT</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>23</b> Year <b>1966</b>		5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>9-16-1887</b> 9. AGE (In years last birthday) <b>78</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MOOREFIELD, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DAVID SCOTT</b>			14. MOTHER'S MAIDEN NAME <b>LAURA WILSON</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <b>236-20-9956</b>		17. INFORMANT <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte imbalance?</b> 4500 DUE TO <b>Generalized arteriosclerosis, nasal bleeding &amp; emphysema of lung (pleural cavity)</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>12:10 to 10 A.M.</b> , 19 <b>1966</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>12:10 A.M.</b> , from the causes and on the date stated above.									22b. DATE SIGNED
22a. SIGNATURE <b>V. M. Valls</b>			M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>113-A S. CENTRE ST., CUMBERLAND, MD</b>				
22c. PHYSICIAN'S NAME (Type) <b>DR. V. M. VALLS</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-26-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oliver Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Moorefield, W. Va</b>			
24. FUNERAL DIRECTOR <b>Charles B. Berush</b>			ADDRESS <b>Moorefield, W. Va</b>		25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

00070

00071

HARDY

ALLEGANY

MOOREFIELD

25 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

JANUARY 23 1967

SCOTT

W.

CONWAY

2-15-1967

DALE WHITE

MOOREFIELD, W. VA. U.S.A.

DETROIT FARMER

LAURA YILSON

DAVID SCOTT

MEMORIAL HOSPITAL - CUMBERLAND, MD.

2:10 A.M.

DR. V. N. VALLS

113-A 21 CENTRE ST., CUMBERLAND, MD.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00072

00071

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>1 HOUR</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>VALE SUMMIT</b>		d. STREET ADDRESS <b>VALE SUMMIT</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS' HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>JOHN</b> Last <b>SLEEMAN</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>2</b> Year <b>1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 6, 1924</b>		9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months <b>41</b> Days <b>41</b>	IF UNDER 24 HRS. Hours <b>41</b> Min. <b>41</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HELPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GARAGE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VALE SUMMIT, MARYLAND U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH SLEEMAN</b>				14. MOTHER'S MAIDEN NAME <b>AGNES HIGGINS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-16-2626</b>		17. INFORMANT <b>MRS. LOUIS SLEEMAN, VALE SUMMIT, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4201 DUE TO (b) <b>1 hour</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> , 19 <b>66</b> to <b>1-2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-2</b> , 19 <b>66</b> , and that death occurred at <b>11:45</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>H. C. Diehl</b>				22b. DATE SIGNED <b>1/4/66</b>		22c. PHYSICIAN'S NAME (Type) <b>H. C. DIEHL, MD.</b>	
22d. ADDRESS <b>39 WEST MAIN STREET, FROSTBURG, MD.</b>				22e. REC'D BY REGISTRAR <b>1 JAN 10 1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 5, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Martha M. Lowers</b>				25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00007

00007

CERTIFICATE OF DEATH

ALL INFORMATION

DEPARTMENT

HOSPITAL

JOHN B. BROWN

JOHN B. BROWN

JULY 6, 1934

WHITE

GALE

GALE

JOSEPH BROWN

JOSEPH BROWN

DECEASED

W. C. BROWN

W. C. BROWN

W. C. BROWN

W. C. BROWN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00073					00072				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		ALLEGANY			a. STATE		MARYLAND		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		MARYLAND			b. COUNTY		ALLEGANY		
CUMBERLAND		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		LONOCONING		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
SACRED HEART HOSPITAL					2 DOUGLAS AVE.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH
MARGARET			P		SMITH		1/6/66		19
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/25/92		73 yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
House Wife					Lonaconing, Maryland		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Robert Creighton					<del>PATIENT'S DAUGHTER</del> Janet Pollock				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
					PATIENT'S DAUGHTER				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 1 day 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4-9, 1967, to 1-6, 1966, that (I) (we) last saw the deceased alive on 1-2, 1966, and that death occurred at 4 M, from the causes and on the date stated above.									
22a. SIGNATURE L. E. Ballin					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-6-66		
22c. PHYSICIAN'S NAME (Type) DR. BALLIN					22d. ADDRESS 62 Greene St., Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			1/8/66		Memorial Park		Frostburg Md		
24. FUNERAL DIRECTOR George Eichhorn					ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR JAN 10 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge

00023

00023

CERTIFICATE OF DEATH

U.S.A.

Housewife

Robert Greifson

Robert Greifson

I was

Coroner's decision

4 years

Coroner's decision

22

1 - 6

12

1 - 2

22

1 - 2

1-6-66

x

So 11.02

11.02

10

10

10

10

10

10

10

1  
FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00074

00073

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>9 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>267 Williams Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Leo</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1907</u>
9a. AGE (In years last birthday) <u>58</u> yrs.		9b. IF UNDER 1 YEAR Months <u>01</u> Days <u>1</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee of Celanese Corp of America</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brunswick, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry E. Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Nellie V. McBee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-2645</u>	
17. INFORMANT <u>Mrs. Gladys L. Snyder</u>		Address <u>267 Williams St Cumberland, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		22. DATE SIGNED <u>Jan 24, 66</u>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u>		Address (Street, city, town, or county) <u>Route #9 Cumberland, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland Maryland</u>
24. FUNERAL DIRECTOR <u>Ruth E. Silcox</u>		ADDRESS <u>Cumberland Maryland 21502</u>	
25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00030

00030

*Bureau of the Interior*

1  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>CERTIFICATE OF DEATH</b>											
00075		Item #8 Film #G372 1/18/66 pc				00074					
1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt 3 Cumberland</u> c. LENGTH OF STAY IN 1b <u>Thermal Rd. Rt 3 Cumberland, Md</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt 3 Cumberland</u> d. STREET ADDRESS <u>Thermal Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Helen Seymour Steiner</u>					4. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 9, 1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey Coffman</u>					14. MOTHER'S MAIDEN NAME <u>Mary Gurm Coffman</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes give war or date of service)		17. INFORMANT <u>Mrs. Melvin Critzman</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <u>3 mon.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <u>19</u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>11-25</u>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-25</u> , 19 <u>65</u> , to <u>1-11-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-1-</u> 19 <u>66</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>W.C. Spiggle</u>					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>W. C. Spiggle, M.D.</u>					22d. ADDRESS <u>126 N. Smallwood Street, Cumberland, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 15 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>S.S. Peter + Paul Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>					ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



000000

000000

Handwritten notes and signatures, including "Catherine of England" and "Mary Queen of Scots".

Handwritten notes and signatures, including "W. G. L." and "C. G. L.".

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Allegany		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R. F. D. #1		d. STREET ADDRESS R. F. D. #1	
3. NAME OF DECEASED (Type or print) First Middle Last Bernard W. Stokes		4. DATE OF DEATH Month Day Year Jan. 28 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1905
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Will Stokes		14. MOTHER'S MAIDEN NAME Hattie May Sweitzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-05-5608	
17. INFORMANT Mrs. Dora Stokes, Oldtown, Md. - Wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) ***		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		22. DATE SIGNED JAN. 28, 1966 Cumberland, Md.	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 1, 1966	
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR FEB 4 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

10038

10038

10038

*Robert Johnson*

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, the funeral director should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>		d. STREET ADDRESS <b>WRIGHTS CROSSING</b>	
3. NAME OF DECEASED (Type or print) First <b>CECIL</b> Middle <b>LEROY</b> Last <b>TOMLINSON</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>21</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 1, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FILTRATION DEPT.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE CORP.</b>	9. AGE (In years last birthday) <b>63</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CECIL TOMLINSON</b>		14. MOTHER'S MAIDEN NAME <b>CHARLOTTE SIRES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-07-2607</b>	
17. INFORMANT <b>DONALD TOMLINSON</b>		Address <b>BOX 36, ROUTE 1, FROSTBURG, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRANSECTION OF SPINAL CORD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(STRUCK BY AUTOMOBILE)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>PEDESTRIAN STRUCK BY AUTOMOBILE</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>8:30</b> a.m. <b>Jan. 21</b> 19 <b>66</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 36 2 mile south of Frostburg, Alleg. Md.</b>	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		22. DATE SIGNED <b>January 21, 1966</b>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1-24-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial</b>	23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b>
24. FUNERAL DIRECTOR <b>Joseph R. Dunst Jr.</b>		25a. REC'D BY REGISTRAR <b>Jan 26 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Johnas Judge</b>

00000

00000

00000

BURIAL 1-24-1911

Joseph R. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

00078

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 DR. NADEAU

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

00077

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 HR. 44 MIN.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>306 BEDFORD STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>VERNA</b> Middle <b>GAILE</b> Last <b>VALENTINE</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>7</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-6-66</b>
9. AGE (In years last birthday) yrs. <b>44</b>		10. CITIZEN OF WHAT COUNTRY? <b>44</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FRANK R. VALENTINE</b>		14. MOTHER'S MAIDEN NAME <b>DELORES JILL EVANS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776 X</b> DUE TO <b>Immaturity</b> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Oliver H. Nadeau</i>		22b. DATE SIGNED <b>1-8-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. OLIVER H. NADEAU</b>		22d. ADDRESS <b>600 VIRGINIA AVE., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>1-9-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR <i>John A. Moberly</i>		25a. REC'D BY REGISTRAR <b>JAN 12 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

6-168836



00000

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00079					00078					
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>45 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6 King Street</u>					d. STREET ADDRESS <u>6 King Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Clarence</u> <u>Howard</u> <u>Williams</u>			First Middle Last		4. DATE OF DEATH <u>Jan.</u> <u>10</u> <u>19</u> <u>66</u>		Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1891</u>		9. AGE (In years last birthday) <u>74</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pipefitter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Tire Industry</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Giles County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Williams</u>					14. MOTHER'S MAIDEN NAME <u>Georgie Perkins</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>220-10-2023</u>		17. INFORMANT <u>Mr. Basil Williams, Cumberland, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thaemia</u> <u>4221</u> DUE TO (b) <u>myocarditis &amp; Decongenation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>3 mon</u> <u>5 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1, 1965</u> , to <u>Jan. 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan. 4, 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Clay E. Durrett</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 10, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Clay E. Durrett, M.D.</u>					22d. ADDRESS <u>236 Virginia Ave., Cumberland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Jan. 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>			
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>					ADDRESS		25a. REC'D BY REGISTRAR <u>JAN 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00078

00078

CONFIDENTIAL NO ORIGIN

CONFIDENTIAL  
NO ORIGIN

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "CONFIDENTIAL" and "NO ORIGIN" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>65 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>706 Avondale Avenue</b>						d. STREET ADDRESS <b>706 Avondale Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Elizabeth</b> Last <b>Wingate</b>						4. DATE OF DEATH Month <b>Jan.</b> Day <b>2</b> Year <b>1966</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 5, 1879</b>		9. AGE (in years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harpers Ferry, W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Michael Keller</b>						14. MOTHER'S MAIDEN NAME <b>Ellen ?</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. G. Ray Light, Cumberland, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Crown Myocarditis</b> (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery</b>												INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>5 yrs</b> <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.													
22a. SIGNATURE <b>J. W. Eliason</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan. 3, 1965</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. H. W. Eliason, M.D.</b>						22d. ADDRESS <b>203 Greene St., Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 5, 1965</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>					
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>JAN 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

00079

00079

*My dear Mr. [illegible]*  
*Thank you for the [illegible]*  
*which I have received.*

*Yours faithfully,*

*[Signature]*

2 1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE</b>			c. LENGTH OF STAY IN 1b <b>1 year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D. O. A. Miners Hospital</b>					d. STREET ADDRESS <b>01-1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gary</b>			First <b>Gary</b> Middle <b>Elliott</b> Last <b>Witt, Jr.</b>			4. DATE OF DEATH <b>Jan. 5 1966</b>		Month <b>Jan.</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 6, 1964</b>		9. AGE (In years last birthday) <b>1</b> yrs. IF UNDER 1 YEAR: Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gary Witt, Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Yvonne Werner</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Gary Witt, Sr.</b> Address <b>Mt. Savage Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9220 ASPHYXIATION</b> DUE TO (b) <b>LARYNGOSPASM</b> DUE TO (c) <b>(CHOKED ON ASPIRIN)</b>								INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>MINUTES</b> <b>MINUTES</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>CHILD TOOK PILL BY HIMSELF</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:00 p.m. Jan. 5 1966</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Mt. Savage, Alleg. Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22. DATE SIGNED <b>January 5, 1966</b>	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				Address (Street, city, town, or county) <b>Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 8, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Mt. Savage, Maryland</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. READ BY REGISTRAR <b>JAN 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			



00000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00000

00000

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] RACE: [illegible] BIRTH DATE: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE OF DEATH: [illegible]

UNDERLYING CAUSE OF DEATH: [illegible]

DETAILED HISTORY OF ILLNESS: [illegible]

PREVIOUS MEDICAL HISTORY: [illegible]

TESTS AND EXAMINATIONS: [illegible]

POSTMORTEM EXAMINATION: [illegible]

LABORATORY TESTS: [illegible]

TOXICOLOGY: [illegible]

OTHER TESTS: [illegible]

DATE OF EXAMINATION: [illegible]

TIME OF EXAMINATION: [illegible]

PLACE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF SIGNATURE: [illegible]

TIME OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		MARYLAND		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		FROSTBURG		c. LENGTH OF STAY IN 1b		2 1/2 weeks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		MINERS HOSPITAL		d. STREET ADDRESS		2 ORMOND STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
SADIE		MARIE		YEAGER		JANUARY		5,		1966	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MARCH 7, 1916		49 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
HOUSEWIFE		OWN HOME		FROSTBURG, MARYLAND		U.S.A.					
13. FATHER'S NAME		ANTHONY LA PORTA		14. MOTHER'S MAIDEN NAME		SADIE BOLLINO					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		FROSTBURG, MD.			
NO		214-12-3828		MRS. JAMES E. KELLY, 87 E. MAIN ST.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		170X		DUE TO		Massive Pulmonary Embolism the bone		INTERVAL BETWEEN ONSET AND DEATH		30 seconds	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		Advanced Metastatic Carcinoma of				10 months?	
		(c)		DUE TO		Adenocarcinoma of the rt. breast				6 yrs?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from APRIL 1965 to JAN. 1966 that (I) (we) last saw the deceased alive on JAN. 1966, and that death occurred at 11:15 M., from the causes and on the date stated above.											
22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
Martin M. Rothstein M.D.		1/6/66		MARTIN M. ROTHSTEIN, M.D.		48 BROADWAY, FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
BURIAL		JAN. 8, 1966		ST. MICHAEL'S CEMETERY		FROSTBURG MARYLAND					
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
HAFER FUNERAL HOME, 60 W. MAIN ST. Frostburg, Md.		JAN 10 1966		Charles Judge							

18907

\$8000